October 1961

Mental Hospitals

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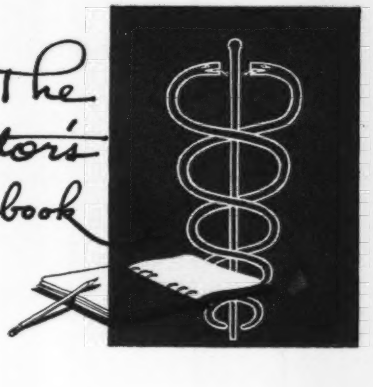
*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.

The Editor's Notebook



Psychiatrists are not immune from the legitimate public expectation that they, as physicians, will be prepared to take charge of a medical or psychiatric emergency, no matter what the hour. A situation which may involve both is when a mentally anguished human being loses his sense of identity and is so overwhelmed by his anxiety that he contemplates or actually attempts suicide. If we can but frustrate this impulse by making psychiatric help readily available, we may be able to avoid the additional burden upon the patient and upon ourselves of having to deal with the symptoms of poisoning, drowning, self-mutilation, and the like.

It is true that we know too little about the dynamics of suicide. Statistically, we are told, it is tenth among the killers in the United States. But as the late Gregory Zilboorg commented " . . . suicide cannot be subject to statistical evaluation, since all too many suicides are not reported as such."[1] But we do know that the individual contemplating self-destruction affords us some clues and, if a helping source is available, may even telephone or come in to get protection against his impulse.

In Los Angeles, the Suicide Prevention Center has been operating under a research grant from the NIMH since 1958. Early findings indicate that suicide threats by men are more likely to be serious than those by women, although the latter, perhaps because of their more dependent role, seek help more readily. Litman, the psychiatrist who directs the service, and Kaphan, the chief psychiatric social worker, have developed three separate goals. First, the social worker who receives the initial telephone call sustains the contact by deliberately encouraging dependency, meanwhile offering calm, hopeful comments, in which the word "help" is repeated. Next she evaluates as quickly as possible what type of intervention is needed—a personal visit by the patient or, perhaps, his referral to an appropriate community resource. And, finally, an attempt is made to motivate the patient himself to some preventive action. The chief assets in the situation are the incipient relationship which is formed during the first words of the conversation, and the patient's own ambivalence toward death. The Los Angeles experience confirms our knowledge that the potential suicide usually gives clear and recognizable clues to his intention, and will often actually seek assistance to protect himself.

In Boston, a city-wide service known as "Rescue Incorporated" has achieved almost national fame. Its phone number is listed on the front page of the city telephone directory, and it maintains an office in the fire department, thus offering front-line psychiatric service when would-be suicides have to be coaxed down from window-ledges or rooftops. Its headquarters is at the Boston City Hospital, and psychiatric residents rotate on the suicide-prevention service, thus obtaining first-hand information and experience which will be invaluable in their future work.

The family physician likewise needs some education in handling suicidal episodes, since it is often he who receives the agitated call from anguished relatives or perhaps the patient himself. More suicide-prevention centers would provide him with a reliable source to which he could refer such emergencies if he does not feel able to handle them himself.

Most suicide-prevention programs are found in big cities, often connected with the psychiatric section of a large city hospital. Smaller general hospitals, in the suburbs or other less-impacted areas, which are rapidly becoming a front-line resource for the treatment of brief mental illness, should make similar provisions. Outpatient clinics connected with state mental hospitals are also ideal sponsors for suicide-prevention programs.

Our responsibility does not end, of course, once the attempt at suicide has been thwarted. The presenting symptom—suicide—must be handled immediately and effectively, but the sufferer is likely to need longer-term supportive therapy in one form or another. More information is needed about second and third attempts at self-destruction, and psychiatric residents, as they learn or develop the techniques of prevention, must be able to apply the knowledge they have gained about the patient to his future treatment.

In suicide prevention, as in all other pychiatric areas, we come back to our original threesome—treatment, training, and research. A psychiatric suicide-prevention center meets urgent human needs, gives all members of the treatment team excellent practical experience, and affords ample opportunities for us all to acquire more basic knowledge.

Matthew Ross, M.D.

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[1] *Zilboorg, Gregory: Suicide Among Civilized and Primitive Races, American J. Psychiatry 92:1350, May 1936.*

A Day-Care Program for Adolescents in a Private Hospital*

By CHARLES H. JONES, M.D., *Superintendent*
Butler Health Center
Providence, Rhode Island

DAY-CARE PROGRAMS described in psychiatric literature seem to have begun as departures from preexisting operations. Thus, Butler Health Center's demonstration project for adolescents is different because it evolved as an extension of a general day-care program which started from scratch in 1957. The general program was initiated for the very pragmatic purpose of putting idle facilities to work to create income for a health center and to provide a new psychiatric service desired by the community.

In 1955, Butler Hospital closed its doors for economic reasons after an uninterrupted operation of 111 years. In response to extraordinary public dismay at the hospital's closing, the Board of Trustees sought help from Dr. Daniel Blain, then medical director of the American Psychiatric Association. In turn, Dr. Blain solicited the cooperation of 19 prominent psychiatrists who, with the trustees, investigated the feasibility of reopening Butler.

After carefully evaluating the hospital and the state's psychiatric resources, the APA group decided that Butler should not be revived as an institution solely for inpatients. Instead, they suggested that the hospital's extensive facilities be used to develop a community health center, based on private hospital operations of reduced scope. After a short fund-raising campaign to which the community responded generously, the hospital reopened its doors in 1957 as the Butler Health Center. Since that time, nine local health and welfare agencies have moved into remodeled quarters on the hospital grounds.

Among the APA recommendations was the following: "In general, an enlarged outpatient Day-Care Service would fit into the expanding concept of hospitalization, would fill the demonstrated and often mentioned needs of the community, and, if it were significantly large and penetrated into all phases of community need, would be unique in the United States. While Butler Hospital had an Outpatient Service in the past, the idea presented here is one of a vastly expanded clinic service and of a Day-Care Program where patients would receive six to ten hours of care daily in a hospital setting."

Mr. George Moore, chief of the Division of Vocational Rehabilitation for Rhode Island, was one of the first local agency directors to recognize the economic feasibility of cooperative programs with Butler Health Center. For some time his organization had been authorized to pay for psychiatric services for clients whose mental or emotional problems precluded employment or continuation in school. Therefore, Mr. Moore was able to assign a rehabilitation coordinator to Butler when it reopened. We started a Day-Care Program on April 15, 1957, on a small scale. On June 1, we began a larger demonstration project under the auspices of the DVR from which we received a special project grant. This preceded the opening of a 40-bed unit for inpatients by six weeks.

Economically Sound Program

Financial support from the division has since consisted of a fee graduated to a maximum of $45 for each psychiatrically evaluated patient, depending on whether or not psychological and social service appraisals have been indicated, and $8 per day for each accepted patient attending the program. This daily cost is decidedly below that of private inpatient care and compares favorably with state hospital inpatient costs when weekends, holidays, illness, and various causes for absenteeism of day-care patients are considered.

While psychiatric care for adults and children has been provided for many years in Rhode Island, little or none has been available for adolescents. Therefore, it seemed to be significant that during the three-year general day-care demonstration project, 22.8 per cent of the patients were under 21 years of age. Consequently, a new demonstration was proposed to extend the use of day-care treatment for adolescents of from 15 to 21 years of age by closely integrating a program with the activities of other state health and welfare agencies. Accordingly, the Federal Office of Vocational Rehabilitation approved a grant for this purpose and we started the project on June 1, 1960.

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*Revised version of a paper read at the 117th Annual Meeting of the APA, May 1961, Chicago, Ill.

The beginning of the new project was coincidental to my arrival at Butler as superintendent. I decided to develop it along the lines of my state hospital experience by prescribing patient-activities individually. I have long been convinced of the value of having a single doctor responsible for all aspects of the hospital management of a given patient. This helps the doctor to regard as medical responsibilities the tasks of tailoring a patient's activity schedule and following his progress.

Twenty-seven employees of the hospital are involved, full- or part-time, in the Day-Care Program, but only full-time psychiatrists are immediately responsible for prescribing patient-activities. When it is desirable, the psychiatrists consult with other staff members. In addition to their own therapeutic sessions with patients, they prescribe industrial assignments, school, occupational therapy, hobby shop, recreation, and social activities. Industrial assignments include housekeeping, greenhouse and grounds maintenance, work in the culinary and nursing departments, clerical work in the business office, at the switchboard, and in the occupational therapy office.

Circumventing Supervisory Pitfalls

To avoid the chaos which usually results when all personnel attempt to relate therapeutically to all patients, we assigned a male psychiatric nurse to full-time supervision of industrial assignments. He supplements the psychiatrists' direct contacts with other personnel by acting as go-between. This administrative organization allows non-professional personnel to concentrate their attention solely on the patients assigned to them; they do not need to be familiar with all cases or concerned with the ramifications of all interactions of patient-groups.

Nonetheless, nonprofessional personnel make contributions to the hospital milieu; these contributions are nonspecific in respect to a given patient assigned to others, but consist of attitudes of matter-of-fact, arms-length acceptance by all. This administrative organization permits the physician and the personnel he has chosen to help him to deal with the patient's problem of relating to others.

The DVR has 19 full-time counselors in Rhode Island. Many serve general groups of rehabilitation clients; some have specific assignments, such as the counselor located at the state hospital and the three assigned to the public schools. A variety of community agencies refer patients to counselors. Patients entering day-care are screened three times: first, by the referring source; second, by a counselor who evaluates vocational feasibility; and third, by a physician at Butler who determines from a psychiatric standpoint whether or not the patient should be admitted to the Day-Care Program.

A breakdown of the first 100 cases scheduled by the DVR for examination at the hospital shows the extent to which community agencies have made referrals. The original source of referral to the division was a hospital or physician in 22 per cent of the cases, a community health or welfare agency in 27 per cent, school personnel in 44 per cent, and the patient or a friend in 7 per cent. Among the community health and welfare agencies that referred patients for day-care were the Division of Probation and Parole, Juvenile Court, Division of Public Assistance, Training School for Girls, Department of Employment Security, Training School for Boys, Pawtucket Family Service, Child Welfare Services, Rhode Island Big Brothers, Providence Family Service, and St. Mary's Home.

After psychiatric examination, the following recommendations were made for 81 cases: authorization for day-care, 34; authorization for outpatient therapy at Butler, 25; continuation of work or school under a counselor's guidance, 17; others, 5. Nineteen clients failed to report for evaluation, 32 were admitted to the Day-Care Program and 10 were admitted to the Butler Outpatient Service. While referrals to Butler from the DVR were for day-care evaluation, some psychiatric reports were returned which were useful in working out vocational plans other than day-care. In other words, the day-care evaluation process at Butler has served as a psychiatric component of the DVR.

Types of Service Defined

To date, the Day-Care Program has served three general categories of adolescents. The first is composed of those who have had no former record of mental illness and for whom day-care was the first contact with psychiatric services. Day-care may have been an alternative to hospitalization for some, but we believe that it was more specifically suitable for these patients than either hospitalization or outpatient treatment.

The second category consists of those who have had previous ambulatory psychiatric treatment either on a private basis or in connection with an agency or hospital outpatient service. For them day-care constituted an immediate service between ambulatory care and hospitalization.

The third category contains adolescents who have been hospitalized in a mental institution. For the ones who have come to the program directly from hospitalization, day-care is useful as a rehabilitation service. For those who have experienced a considerable time-gap since hospitalization, day-care is a refuge during exacerbations of symptoms. For others, whose patterns of illness have caused alternations between hospitalization and other arrangements for treatment, day-care became a testing ground for gains made.

The use of day-care for rehabilitative purposes by the DVR has brought several extra dividends. It has made day-care available to private patients who, otherwise, could not have been accommodated in such numbers in a program operated solely for them. Some of the private patients were admitted directly by Butler's associate staff, composed of 27 psychiatrists in private practice in Providence. Others have been admitted from the hospital Inpatient Services by either associates or full-time Butler staff.

Day-Care Program activities also have been helpful in making daily social and recreational schedules for inpatients. We have intermingled day-care and outpatients only in group psychotherapy, which has aided the transfer of some patients from day-care to the Outpatient Service. Our experience of integrating Day-Care Program activities with those of the Inpatient and Outpatient Services has been fruitful.

Administrative Structure

Over-all administrative control is exercised at weekly meetings by physicians, social workers, sociologists, nurses, psychologists, occupational therapists, a school teacher, and a part-time vocational counselor, all of whom have definite assignments to the Day-Care Program. A job placement officer from the Department of Employment Security attends almost every week. Occasionally, other vocational counselors attend as a part of inservice training. One, now stationed full-time at the state hospital, came to Butler daily for two weeks as part of such training.

Representatives from The Boys Training School and the Division of Probation and Parole have attended conferences to discuss specific patients. At these weekly meetings one of the registered nurses has given a short report on each patient. Although these people discuss only superficial clinical and administrative aspects of the cases, the cumulative effect has been most helpful in establishing administrative policies and in planning supervision by other community agencies as day-care has been completed. One of our objectives is to refine methods for selecting the type of adolescent patients who are inadequately provided for by other community agencies but who can be helped by our approach.

A statistical appraisal of our patients' clinical progress would be premature now, but we can offer several tentative impressions. Adolescents, representing all diagnostic categories, can be served by a program of this type—many for as long as six months. Their good attendance indicates their satisfactory acceptance of the program, and we find that they are equally amenable to psychotherapy for reactions external to the program and for those arising from participation in it. It appears that social pressures they meet in the Day-Care Program are less acute than those previously experienced at school, work, and home. We believe that we are making a particular contribution to patients who display adjustment reactions to adolescence—poor school performance, truancy, acting-out behavior, and drop-out—caused by conflicts at school or at home.

The following case history of a 16-year-old boy illustrates the favorable outcome of five months' participation in the Day-Care Program. This boy, once confined to the Rhode Island Training School, was referred by his probation officer to the DVR, and then to Butler. He had been in the training school several times for breaking and entering and, when ready for release, could not be discharged because of poor home conditions. His father was on the alcoholic ward of the State Hospital for Mental Diseases. His mother was physically ill and emotionally unstable. His four younger brothers and sisters were living in orphanages. In the past, the boy had often been placed in similar institutions during family crises. His behavior and progress in the training school had been exemplary; he consistently received superior ratings in various intelligence tests.

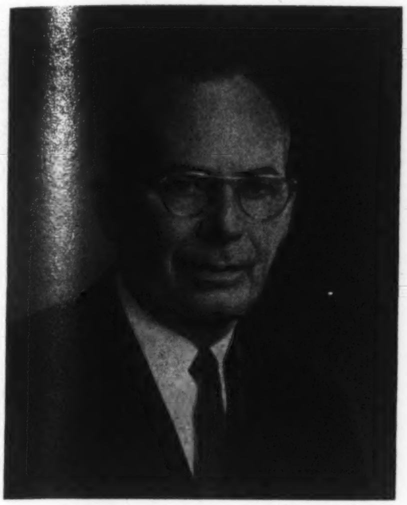
When admitted to the Day-Care Program on January 31, 1961, he was very discouraged and despondent. Although capable of good performance, he did not want to work toward graduation from high school and was pessimistic about his future. During his first six weeks in Butler's two-hour school program, his attendance was regular and prompt; he did his work well and requested some harder assignments. However, during the last half of his Day-Care Program he successfully manipulated personnel with the result that he became casual about his school work and lost interest. Simultaneously, his depression and feelings of insecurity and unworthiness diminished.

Personal Success in the Making

Despite his past history, he never demonstrated sociopathic trends. He regularly attended group therapy meetings, and other adolescents in the group seemed to depend upon him for advice and leadership. During individual psychotherapeutic sessions, he was able to express his ambivalent feelings toward his parents, finally realizing that his mother had made him feel guiltily responsible for an extremely poor family situation which he had not created. His physician believed that his previous sociopathic behavior was motivated by deep emotional family conflicts and, in a sense, represented one of the boy's last defenses against a psychotic reaction. His superior intelligence and outgoing personality were assets which helped us to plan for his release.

We discharged the boy on June 26, 1961, to attend the New England Technical Institute where he will study to become an electronic technician. The responsibility for his case now rests with the DVR counselor who made the original referral. If the boy needs additional psychiatric help during future crises, he can be admitted to Butler's Outpatient Service for follow-up by the same psychiatrist assigned to him in the Day-Care Program.

This case illustrates significantly how the Day-Care Program works with and depends upon other community agencies. As our demonstration project proceeds, we hope that its services will be utilized more and more by a variety of agencies throughout the state. •



The National Association of Private Psychiatric Hospitals— Its Objectives and Potentials

By EDWARD G. BILLINGS, M.D.
President, NAPPH
Denver, Colorado

THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS greatly appreciates the invitation of the editor of *Mental Hospitals* to provide information about NAPPH for publication.

It would be impossible to tell the whole story of NAPPH in a few words. The association has existed for 28 years and is composed of 130 member hospitals located in 37 states, Canada, and Puerto Rico. A relatively small medical organization, it is a very active one and perhaps unique because practically every member hospital is represented in the 16 hard-working committees and 20 study groups. These integrated committees and study groups afford a forum for the exchange of ideas so that we all can benefit from the experiences of others in improving administration, care and treatment of patients, and relations with physicians and the public.

The public and staffs of general hospitals that lack psychiatric units often see the private psychiatric hospital essentially as a place for the care of the rejected aged, alcoholic, or wealthy person who desires respite from the world's stress and strain. This picture, of course, is grossly distorted. In fact, our private institutions, which provide about 2 per cent of all psychiatric hospital beds, annually admit approximately 40 per cent of patients entering mental hospitals of any kind.

State and federal psychiatric hospitals are primarily for those who cannot afford private care; those requiring indefinite, long-term hospitalization; or groups, such as veterans, who are entitled to medical benefits. Emotionally ill citizens with middle incomes can turn for help to private psychiatric hospitals and general hospitals that have psychiatric units.

Therefore, one of the NAPPH objectives is to collaborate with medical, hospital, and psychiatric organizations—especially state medical societies and APA district branches—in order to: (1) provide better facilities and care for the average citizen who wants and should have private care of his own choice, and (2) augment the too-few in psychiatry who care for the too-many by lending NAPPH facilities and talents to upgrade government-supported psychiatric facilities, assist in psychiatrically educating the family doctor, encourage research, and train medical and ancillary personnel in psychiatric procedures.

NAPPH will hold its next annual forum January 22-24, 1962, at the Colony Beach Resort, Sarasota, Fla. At this time, the study groups will report on their work and give their recommendations. Association members will discuss with representatives of general practice, state and federal administration, general hospitals, and others how the private psychiatric hospital can better fulfill its objectives.

In the meantime, I hope that NAPPH members will accept the editor's invitation to submit papers for possible publication—either papers resulting from the study groups or those written independently by staff members of private psychiatric hospitals. Psychiatric patients in both private and public hospitals present staff members with similar problems. Thus, private hospital material is useful and valuable to state and federal hospital staffs, just as theirs is to us.

Authors may submit papers directly to the APA Central Office in Washington, D.C., or through our executive secretary, Mr. Melvin Herman, who works closely with the magazine's editorial staff. His address is 153 Lakeview Ave., Leonia, N.J. •

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From the Literature

Excitement Following Electroconvulsive Therapy

Murray[1] administered parenteral Sparine (with atropine sulfate, succinylcholine dichloride, and a barbiturate) to 50 patients prior to electronconvulsive therapy. Observations were conducted during 497 individual treatments.

The salutary effects of Sparine, which Murray attributes to enhancement of barbiturate action, were evident in improved behavior, diminution of agitation following treatment, and prolongation of sleep. No significant blood pressure fluctuations or cardiovascular abnormalities were noted in any of the patients.

Excessive Psychokinetic Activity

Graffeo[2] selected 180 chronic, hospitalized psychotic patients at random on the basis of increased psychokinetic activity manifested by restlessness and agitation, or complications or lack of improvement with other chemotherapeutic modalities.

Sparine was administered orally in dosages graded to the psychokinetic activity of the patient.

Of the 180 patients, 72 percent showed marked to moderate improvement in behavior, and no patient's behavior worsened. Almost half of the patients showed marked to moderate improvement in their psychoses; in 3 percent mild regressive tendencies were noted. According to the author: "Promazine [Sparine] adequately modified the formerly disturbed behavior pattern of the chronic schizophrenic patients so that psychotherapy was facilitated and, as a result, made it possible for 26 patients to be released from the hospital."

Alcoholism

Figurelli[3] has found that the use of Sparine in uncomplicated cases of acute alcoholism controlled symptoms of active delirium, as well as nausea and vomiting, and drastically reduced mortality rates. According to Figurelli "... medication with promazine [Sparine] enables more rapid control of delirium, eliminates the prolonged and more expensive therapeutic measures which formerly were the only recourse ... and permits earlier return of the patient to gainful occupation." Parenteral Sparine is usually used initially by Figurelli; oral Sparine is used for maintenance. No precipitous drop in blood pressure occurred in the series of patients studied by Figurelli.

Note: The degree of central nervous system depression induced by Sparine has not been great; however, in the acutely inebriated person the initial dose should not exceed that recommended to be sure that the depressant effect of alcohol is not enhanced. Sparine should not be used in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). In patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable, Sparine should be used with caution.

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1. Murray, N.: Diseases of Nervous System *21*:1 (Aug.) 1960.
2. Graffeo, A.J.: Am. J. Psychiat. *116*:842 (March) 1960.
3. Figurelli, F.A.: J. Am. Med. Assoc. *166*:747 (Feb. 15) 1958.

For further information on limitations, administration and prescribing of Sparine, see descriptive literature or current Direction Circular.

Coping with Chronic Helpfulness*

By SHEILA ROUSLIN, M.S.
Clinical Specialist in Psychiatric Nursing
Rutgers University
New Brunswick, New Jersey

"FOR YEARS A MENTAL PATIENT who gave his orders in Polish drove a horse around the grounds to pick up trash," read a recent short newspaper story. "Recently, the patient was transferred. Now, officials say, they can't find anyone the horse can understand."

Nobody even remotely familiar with public mental hospitals will find that story unlikely. The quiet, cooperative, "helpful" patient is a fixture in hospitals which are all too short of paid staff. A typical example is an "indispensable" woman patient who, for 20 out of her 22 years of hospitalization, had been on the same ward—an admission ward. She did ward work from the day of her admission and soon took over the kitchen, saying that it was hers. Through the years, staff records speak of her as "assuming responsibility," "ambitious," "cooperative," "industrious," "dependable," and "very helpful."

Such patients become very useful in meeting the work needs of the hospital, an observation made by Greenblatt[1] and others. For instance, a psychiatric nurse wanted to have a series of therapeutic interviews with a patient who worked in the laundry. Said the charge attendant, "That patient will have to come off your list . . . it will cause too much trouble with Mr. X, the business manager, who is in charge of the laundry." The patient, it turned out, was an integral part of the laundry operation; he was well enough to assume a good deal of responsibility—yet he remained a patient.

It is not that the psychiatric hospital gives tacit approval to a pathological pattern because of its economic needs. What does happen is that the hospital, failing to recognize the behavior pattern as pathological, unwittingly reinforces the very problem which originally caused the patient to be hospitalized.

After conducting studies of patients who were considered valuable workers, we characterized this behavior pattern as "chronic helpfulness." It was found to exist in a substantial number of such patients. The initial uncontrolled clinical observations were confirmed by two systematic investigations.[2]

The Chronic Helper's Behavior Pattern

Operationally, the behavior pattern works as follows: the person has an unmet goal—to be liked—and this produces anxiety; he constantly does things for others in order to be liked; people expect him to be helpful and seek his help, which he gives. At this point, he changes his pattern. He may relax his helpfulness and seek a more mutual relationship, even exhibiting dependence on somebody else; or he may feel rejected because he is "being taken for granted"; or he may expect special privileges or favors in return for the help he gives. The other person, made anxious by the changed behavior pattern, rejects the chronic helper, who becomes anxious again and "feels used."

(We must distinguish here between chronic helpfulness and spontaneous assistance to others. The latter lacks the "demand" quality and is prompted by

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Revised version of a paper read at the 117th Annual Meeting of the APA, May 1961, Chicago, Ill.

[1] *Greenblatt, Milton; York, Richard H.; and Brown, Esther Lucille: From Custodial to Therapeutic Patient Care in Mental Hospitals, New York, Russell Sage Foundation, 1955, p. 9.*

[2] *One systematic investigation is available on interlibrary loan from the Rutgers University Library, New Brunswick, New Jersey. Rouslin, Sheila: An Empirical Investigation of Chronic Helpfulness, M.A. thesis, Rutgers University.*

"wanting to do" rather than by "must do" motivation. The person who offers spontaneous assistance usually feels some satisfaction, whereas the end point for the chronic helper is to "feel used.")

Persons exhibiting this behavior pattern hold themselves in low self-regard. Sullivan[3] defined a person's low self-regard as a ". . . personification (which) is not very estimable by comparison with his personification of significant other people." It is accompanied by uncomfortable anxiety, which the person tries to minimize by camouflaging his low self-regard through indirect operations. Thus the chronic helper seems self-assured in that he takes on huge responsibilities on behalf of other people, while his unconscious purpose is to increase his self-regard.

To quote Sullivan again:

". . . there is a large number of people who appear to go to rather extraordinary lengths to get themselves imposed on, abused, humiliated, and what not; but as you get further data, you discover that this quite often pays—in other words, they get things they want. And the things everybody wants are satisfaction and security from anxiety. Thus these people who get themselves abused and so on are indirectly getting other people involved in doing something useful in exchange."

Quite often, however, it does not pay. The time comes when this compensating pattern no longer works, and repeated rejections lead to unbearable helplessness and anxiety. At this point, the chronic helper becomes a hospital patient.

The Problem Exemplified

One such patient entered the hospital after the death of her aunt—the only person with whom she "could be helpless"—and a series of rejections from the man with whom she had been living. Of her man, she said, "I did everything for him. He tells me a story; I believe him, then he does the opposite. And I say, 'What a fool I am.'" About her family and friends she said, "Nobody wants me for anything but service." Describing her anxiety following the death of her aunt (which occurred during a period when she had temporarily given up her boy friend), she said, "I punish myself for seeing and doing for other people when they don't see me and don't do for me. The hospital is a sanctuary for me," she said, adding that it gave her somebody to talk to.

It was obvious, however, that this was not the only thing the hospital provided. This chronic helper, who had been rejected in her private life, became exceedingly helpful to the patients and the ward personnel. She was always the one who set the tables for meals, did the dishes, cleaned the dayroom, listened to and advised other patients about their problems. The ward personnel unwittingly reinforced her pattern. When she did not volunteer for ward work, she was always assigned. She was asked to do special chores; ward personnel depended on her, and labelled her a "good," a "cooperative," and a "helpful" patient. In using the service she so willingly offered, they supported her pathology. Her central problem was finally formulated through group and individual counseling with the psychiatric nurse.

Another patient, with a similar pattern of chronic helpfulness, began to feel "used" when the ward personnel either rejected her help or rejected her as soon as she made overtures toward dependence. She would become fulminatingly self-abusive and self-destructive, saying, "I don't really want to kill myself, but I can't stop"—in the same sense that she could not stop herself from being chronically helpful. This dependent condition forced the staff to support her. Ward personnel then would solicit and accept her help to appease her, thus reactivating and nourishing her helpfulness pattern until again driven to reject her. This staff-patient interaction resembled a treadmill, turning in the continuous, unbroken line of a circle.

The Two Sides of Work Therapy

This illustrates that although work has a therapeutic potential, it may have an untherapeutic potential as well if used with the wrong patient, as noted by Greenblatt and others.[4] Which potential will be realized depends on the nature of the patient's problem. For the patient with a pattern of chronic helpfulness, the performance of and praise for hospital duties reinforces the pattern, thereby thwarting the opportunity to explore the source of his difficulties.

Because of the widely accepted therapeutic potential of work and the hospital's own need for assistance, the problem of the chronically helpful patient and the problem of the hospital merge in a symbiotic relationship under the guise of therapy. Both problems remain unsolved because the patient, at last in a situation where his pathology is partly successful, has no incentive to get out of the hospital or even to recognize the nature of his difficulty, and the hospital, because the patient remains institutionalized, has an increased financial burden.

The existence of this pattern in a substantial number of patients who are considered to be valuable workers implies that there is a reason why a patient becomes a valuable worker. His behavior has purpose and meaning and can be understood. Since chronic helpfulness is used to compensate for the underlying low self-regard, there is concomitant anxiety. These patients use work to reduce their anxiety and by doing so prevent investigation of its source. There is a strong possibility that they will remain chronically helpful—and hospitalized. The triangle of low self-regard, anxiety, and chronic helpfulness will remain.

The therapeutic plan with such patients would be to remove all opportunities for ward work, and thus allow the underlying anxiety to come forth. Its source, the patient's low self-regard, then could be explored. According to our findings, length of hospitalization and the number of admissions have no bearing on the initial (prehospital) existence of the pattern. This means that the hospital staff has an obligation to become aware of this pathological pattern in newly admitted patients before they become too comfortable in their sick role.

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[3] *Sullivan, Harry S.: The Interpersonal Theory of Psychiatry, New York, W. W. Norton & Co., 1953, p. 350.*

[4] *Greenblatt, York, and Brown: op. cit., pp. 7-9.*

Comfort, for the chronically helpful patient, yields to chronic illness—another example of the "institutionalization" of patients. This happens because of the widely held view of work as "therapeutic" coupled with the hospital's own financial difficulties in employment of personnel. Ward and administrative staffs must be able to meet their own employment needs and fulfill their work roles so that the patient will not be forced to meet the needs of his purported healers as a pathological means of gaining satisfaction for himself. His real need is to have his low estimation of himself changed by experience, which can only be provided through a therapist and staff who do not reinforce his chronically helpful pattern. •

Paving the Road Out

By DR. WHATSISNAME

Sometimes a patient clings to the hospital because of a realistic appraisal of his dismal prospects in the outside world. The extent of the hospital's responsibility to improve these prospects is controversial.

During the past decade, hospitals accepted increasing responsibility for helping the patient to adjust himself. They established outpatient departments, halfway houses, sheltered workshops, and patients' clubs. Lately, however, a counter-trend has set in: the theory is that if the hospital refuses to set up postdischarge facilities, the local community will be compelled to—or shamed into—setting them up.

This gambit is a gamble indeed. Some communities will respond, but many won't. But a hospital with imaginative leadership can develop an exciting discharge program. Its social-service arm can stretch right out into the community, beckoning beguilingly to employers, personnel officers, vocational guidance experts. How about a hospital bureau to find housing, foster-homes, or boarding homes? Patients can start job-hunting while still in the hospital, and volunteers and social-service workers might even offer tactful advice about clothing and grooming. Amateur script-writers on the staff or among the patients themselves might devise dry-run job-interviews to familiarize the job-seeking patient with the stresses and strains of a real job-hunting interview. Clubs for ex-patients or a day center might develop into a sort of ethical Lonely Hearts Agency—let's call it a League of Patients' Friends—to help counteract the demon of loneliness.

There may be no list of such possibilities in any mental hospital manual; they spring from the hearts and imaginations of those who care about their patients' future lives. They offer hospital management a provocative challenge to pave the road to the outside with something more than good intentions.

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references

(1) Winkelstein, A.: Am. J. Gastroenterol. *27*:45-52 (Jan.) 1957.
(2) Pareira, M. D., *et al.*: J.A.M.A. *156*:810-816 (Oct. 30) 1954.

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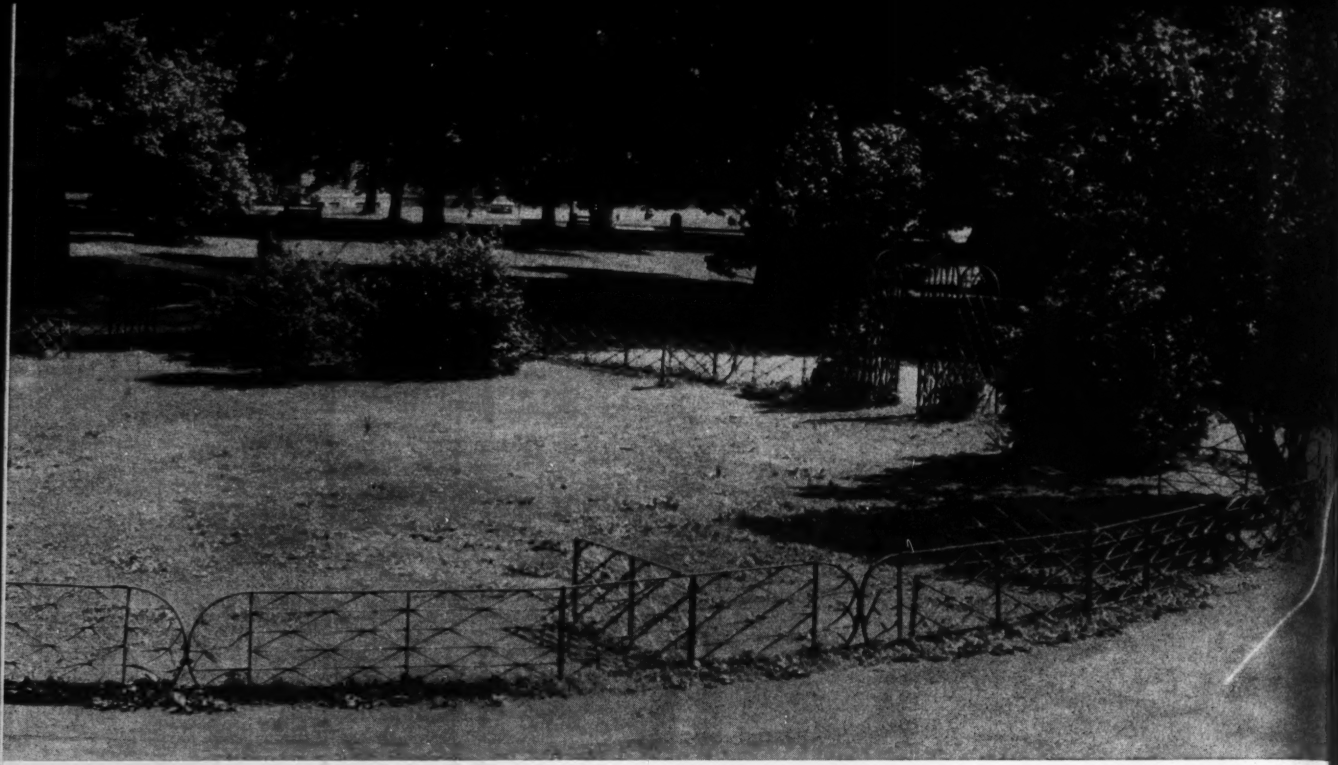

Light as lace and low enough to leap, these black iron former window guards now frivolously fence a patient-planted garden area.

OPERATION— CHANGING OF THE GUARD

By BENJAMIN NUHN, R.N.
Chief Supervising Nurse
Hudson River State Hospital
Poughkeepsie, New York

"IF YOU THINK YOU CAN DO IT, GO AHEAD." With this clearance and encouragement from our director, Dr. Robert C. Hunt, we began the most extensive do-it-yourself project ever instituted at the Hudson River State Hospital—Operation Changing of the Guard.

The hospital was built in 1868 and is one of the oldest in the vast system of the New York State Department of Mental Hygiene. Like most old hospitals, it displayed quasimedieval, barred windows. The immediate objective of Operation Changing of the Guard was to remove the bars.

Sooner or later maintenance men might have torn them down, but the patients just couldn't wait that long. The hospital had adopted the open-door policy in 1957, and only the black iron and galvanized steel window guards remained as incongruous and unpleasant reminders of the old days. "Why open the doors," patients asked, "and keep the windows barred?" Patients' committees from many of the men's services showered physicians and supervising nurses with requests to remove window and porch guards. What they were asking for made sense and represented a normal step in the evolutionary progress toward freedom from the universal restraint of the past.

Once given the go sign, patients moved fast. With the help of ward personnel they quickly commandeered or borrowed bolt cutters, hack saws, hammers, cold chisels, and whatever else they could muster in their attack on the last vestiges of custodial care. Almost overnight, piles of iron bars and scrap mushroomed in the courtyards, on the lawns, and in the storage areas.

Bronze rails grace the main entrance. Formerly used to imprison patients, they now afford protection from falls.

Perplexed with the problem of disposal, we pondered what to do. We could have sold the bars for junk, but, considering that swords can be beaten into plowshares and spears into pruning hooks, we thought we surely could use them more constructively. To see what would happen, we hung onto the old materials.

Soon, the engineering and maintenance divisions of the hospital, as well as enterprising patients and members of the ward staff, went to work, shoulder to shoulder, beating, breaking, bending, and welding the old guards into frames for picnic benches and tables, radiator guards, ornamental grilles, hand rails, storage racks, enclosures for machinery, refuse and trash boxes, garden trellises, fences, gridirons for cookout fireplaces, ventilating doors for steam tunnels and attics, ward settees, and aisle dividers for pedestrian traffic. The pictures on these pages illustrate some of the ingenious results.

The patients inspired Operation Changing of the Guard and they should receive credit for its implementation. Of course, Dr. Hunt and the hospital personnel, who believe "in people doing for themselves what they want to do, whenever it makes sense, rather than their being coerced by authority," encouraged and assisted them.

The project vastly improved patient morale. The red brick buildings have shed some of their somber, prison-like appearance, and the windows submit more readily to being cleaned inside and out. The hundreds of shining panes of glass reflecting the sun's rays—no longer muted by bars—illuminate for the patients, their relatives and friends, and the community an important milestone in patient-care. •

An interior decorator might admire the effect achieved by OT productions arranged on a delicate wrought iron screen.

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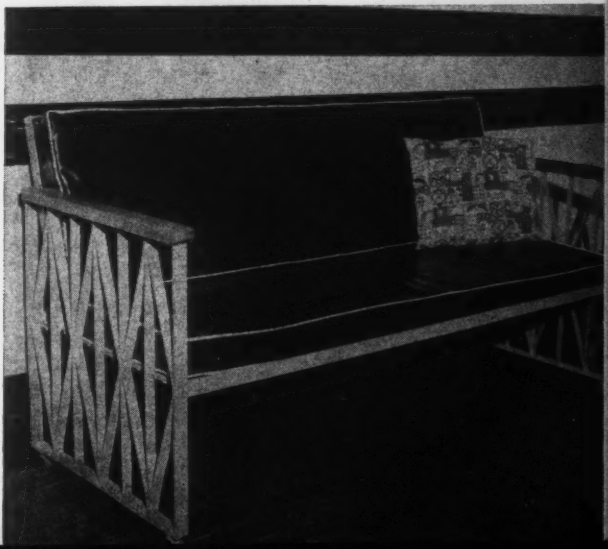

VI. Lawyers and Psychiatrists Must Work out Better Legal Procedures for Hospitalizing Mentally Ill Patients

Legal Requirements for Hospitalization

By PHILIP Q. ROCHE, M.D.
Assistant Professor of Psychiatry
School of Medicine
University of Pennsylvania
Conshohocken, Pennsylvania

THE PSYCHIATRIST is a relative newcomer to the ranks of those who practice the healing arts. He has not yet succeeded in relating his growing knowledge to the law and in eradicating the man-in-the-street's prejudices and fears regarding his specialty. The phenomenon we call mental illness changes with the times. Today we express it more in operational terms that have to do with treatment and less by archaic labels which convey the notion of social danger. There is also less reason for concern about wrongful commitment. But there is far to go in unraveling medicolegal knots that bind psychiatric practice.

The final report of the Joint Commission on Mental Illness and Health recommends modification of traditional practices that have persisted since the beginnings of community responsibility for the care of the mentally ill. Of necessity, the social management of the mentally ill has been in the hands of lawyers—almost completely in the early days, but increasingly shared with physicians in recent times.

Madman and Criminal Equated

Almost 200 years have passed since the first hospital, exclusively for the mentally ill, was founded in the United States. In New York in 1788, the law, borrowed from English Common Law, made provisions only for persons found to be "furiously mad," i.e., dangerous to themselves or to the public. Other states followed this example. A 1797 Massachusetts law—"An Act for Suppressing Rogues, Vagabonds, Common Beggars and other Idle, Disorderly and Lewd Persons"—gave broad authority to the police to segregate disturbing and disagreeable persons, many of whom were probably mentally ill by today's standards.

The madman who disturbed the peace suffered the same consequences reaped by the criminal, although the latter was more fully protected by the Bill of Rights against being deprived of "life, liberty or property without due process of law." In 1806, Virginia took steps to separate the insane from the criminal. Then, in 1827, the New York legislature distinguished between the mentally ill and the criminal; forbade detaining both in the same jail, prison, or house of correction; and provided for the indigent insane to be sent ". . . to places provided for the reception of lunatics."

Beginning of Special Legislation

Appropriate legislation governing involuntary commitment to a hospital had to await the development of community-maintained asylums to replace the earlier private madhouses, jails, and alms houses. In the meantime, many unbelievable abuses existed. In 1867, after agitation by one Mrs. E. P. M. Packard, involuntary commitment by jury became law in Illinois. This mischievous law was not modified until 1893. There were few formal procedures for safeguarding personal rights until after the mid-19th Century when sensational exposés of alleged abuses spurred legislation.

Until recently, the legislative approach to commitment of the mentally ill centered almost entirely on concern for wrongful commitment. In the meantime, most states enacted provisions governing disposition of the property of the insane. It was not until 1845 that the law favored retention of the

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**This paper is one of a series sponsored by the Program Committee for the 13th Mental Hospital Institute. The Institute discussions are to be based upon Action for Mental Health, the final report of the Joint Commission on Mental Illness and Health, which contains important recommendations on research.*

mentally ill, not only as a protective measure but also as necessary for the patients' restoration to mental health. This implied an obligation for the community to actively treat as well as to detain patients.

In due course, all states enacted laws governing involuntary hospitalization of persons believed to be mentally ill. Today, these legal procedures vary from state to state; in all of them there is the lingering notion that the mentally ill person is "furiously mad," and dangerous as the criminal is dangerous. These laws did much to stigmatize mental illness.

Legislation of the latter part of the 19th Century formed a basic pattern which still is in force. During commitment prodeedings, two states now make it mandatory to provide a jury; 11 states do so if it is optioned by the patient. Thirty-seven states provide judicial means of hospitalization. Five continue to employ the sole criterion of danger of the person to himself or others. Twelve expand this criterion by including the patient's need for care and treatment; seven employ the "need for care" as the sole criterion for commitment and use this need to define mental illness. Seven other states define mental illness as a disability requiring hospitalization for the welfare of the patient and others. Five states do not spell out criteria for hospitalization. In Tennessee, a person may be hospitalized for "insanity," but the statute does not define "insanity."

Criteria Start Changing

Thus, we note the trend away from the criterion of danger to self and others to the need for care (hospitalization) and treatment which may be imposed by legal procedure. And further, involuntary commitment implies protective provisions with curative intent. Recently, a Massachusetts statute has defined mental illness to include any person ". . . likely to conduct himself in a manner which clearly violates the established laws, ordinances, conventions or morals of the community." This reaches the delinquent and the criminal. Hospitalization for drug addicts is provided for in 34 states, for epileptics in 18, and for alcoholics in 36. The commitment provisions for these conditions conform to the general pattern for mental illness.

Today, "mental illness" includes the maladjusted, senile, mentally deficient, alcoholic, drug addict, and destitute aged—in fact, anyone alienated from society, and, in fair measure, an increasing number of persons who fall into the category of the antisocial. This enlarging scope has resulted from increased scientific knowledge, greater acceptance of individual human values, and extension of the welfare policy of *parens patriae.* It discards the traditional symbol of the "madman" as a moral derelict or a criminal who must be isolated, and conceives of mental illness as a social and biological phenomenon which can be prevented and cured.

The acceleration of this trend also reflects the effects of communication media which bring to the public a fairly high level of information about contemporary sociology and psychiatry. This information has done much to overcome the isolation of the community from the mentally ill and to erect a more acceptable image of the psychiatrist as physician in contrast to that of the old time alienist as custodian —or, not uncommonly, as "mad scientist." But if tolerance is greater, full public support of mental health still lags—partly because of the sheer magnitude and long-term requirements of the problem which, heretofore, have been met piecemeal and in short-term installments. Nonetheless, today's lawyers are vigilant about the rights of all mentally ill persons, the well-to-do as well as the friendless itinerant poor.

Types of Admission Procedures

In various states the following hospitalization proceedings are now exercised:[1]

1) *Voluntary Admission:* This may be achieved by written application by anyone competent to make such a request. In some states a parent or guardian may make the application. Acceptance for voluntary admission usually imposes a fixed period after admission (usually 60 days) or a period of notice of intended departure (usually 10 days).

2) *Admission by Guardian:* In some states a guardian is authorized to commit a ward without consent of the court.

3) *Nonprotested Admissions:* This procedure gives the patient the privilege of protest at the time of admission. If he does, he may not be received; if he protests after admission he must be discharged within a short time or compulsory proceedings must be instituted.

4) *Emergency Commitment:* This provision is available in almost all states. The proceeding is summary and allows for compulsory detention only for a fixed time.

5) *Temporary Commitment:* This is a more recent development intended for diagnosis and short-term therapy. It is not based on the question of emergency and limits the detention to a maximum period.

6) *Formal Commitment:* This procedure entails indeterminate detention after a formal judicial hearing.

The community is assuming a larger responsibility for the welfare of the mentally ill, and the legal profession is keeping pace. A glimpse at the legal profession's current literature attests to its recognition of the need for renewed study and revision of the laws affecting the rights of the mentally ill, in keeping with our Anglo-American civil rights traditions and with our changing times.

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[1] *Ross, Hugh Alan: Commitment of the Mentally Ill: Problems of Law and Policy, Michigan Law Review 57:953-54, May 1959.*

The mental health movement got substantial impetus from the passage of the National Mental Health Act in 1946. This gave mental health a status beyond local dimensions; it became a national concern. The act established new channels for larger scale operations in the following areas: (1) new research into cause, diagnosis, prevention, and treatment; (2) training of personnel; and (3) assistance to states in the development of mental health programs. Recent state legislation initiated in New York embodied four principles which subsequently have been included in community mental health laws passed in California, Minnesota, and New Jersey. These enactments are permissive rather than mandatory, enabling each community to develop its program at its own pace. Each law provides for state financial support and assistance from state advisory services to local planners.[2]

More Revisions Needed

These types of mental health legislation emphasize the development of prevention, rehabilitation, and treatment services in outpatient and inpatient clinics in general hospitals and community rehabilitation facilities. All depart from traditional, isolated, institutional management of the mentally ill, and, undoubtedly, are steps toward meeting the recommendations of the Joint Commission. Further revisions in our laws are needed to implement these recommendations.

In 1948, the Group for the Advancement of Psychiatry surveyed current commitment procedures in the United States. Its Report No. 4 listed the essentials of satisfactory commitment laws as minimum legal formalism, devices that aim to achieve maximum patient-participation in treatment which includes intramural detention, minimal psychic traumatization in admission procedures, and removal of stigmata, resulting from archaic legal phraseology.

The GAP report also recommends:

1) Whenever possible, eliminating the use of regular peace officers in transporting mentally ill persons. Instead, state hospital or clinical personnel should be delegated or deputized and especially trained for this purpose.

2) Discontinuing all commitments and release procedures having the pattern of criminal procedures.

3) Having the patient's status of indigence and ability to pay determined after his commitment by the state hospital system's fiscal agents rather than by court procedure before commitment.

4) Completely separating commitment procedures from incompetency procedures.

5) Having certification made by two physicians, not necessarily psychiatrists except where they are practicably available.

6) Discontinuing the use of a lay jury to adjudicate any phase of commitment or discharge, the procedure of personal notice served on the patient, and requiring the patient to appear in an open hearing.

The GAP report questioned the use of temporary commitments for meeting "emergency" situations. Temporary commitment procedures provide for detention ranging from 10 to 90 days. Some psychiatrists believe that there is little realistic medical or legal value in temporary hospitalization. Arbitrarily setting the duration of observation and treatment usually handicaps both the patient and the physician in getting to the patient's psychic problem. GAP advocated that all involuntary commitments should be indeterminate. However, current laws favor continuation of independent proceedings for temporary hospitalization by certification with provisions for judicial recommitment.

Voluntary Admission Ideal

Ideally, hospitalization for mental illness should be on a voluntary basis which maximizes the patient's participation in his own treatment. Voluntary admission should not be denied the patient whose capacity is open to doubt. This view was expressed by Flaschner: "A person who is a fit subject for mental treatment should not be denied the easy method for admission merely because he may be too indecisive, weakminded or incompetent to sign his own papers."[3]

Many years before the Joint Commission's suggestions for legal revisions, GAP recommended changes in terminology in statutes, the establishment of a uniform commitment law, provisions for the regulations and standardization of practices of private sanataria, and the establishment of state departments of mental hygiene.

In our projection of legal revisions affecting mental health, we must re-emphasize the patient's rights, which include communication with others outside the hospital, periodic physical and psychiatric reassessments, discharge as soon as possible, the maintenance of civil rights guaranteed by law, and the use of adequate and standard treatment procedures.

In the past 10 years there have been significant developments in the legal aspects of hospitalization. Some states have made substantial revisions both in restructuring the hospital system and in hospitalization statutes. However, the issue of a uniform law for hospitalization has not yet crystallized.

Policy-making in matters of involuntary hospitalization centers on the clarification of the statutory language employed in the various state laws; such revision would attempt to determine the degree of mental illness that justifies involuntary hospitalization. So far, this definition has not been achieved and is unlikely to reach a satisfactory level of precision because of our growing understanding of the meaning of mental illness and the changes in its social character. In the past, legal definitions of mental illness have not rested on psychiatric labels but on broad social concepts. Revision of statutory language is needed to eliminate terminology that retains criminal implications; such terms as "arrested," "warrant," "commitment," and "accused of insanity" no longer have a place in the management of the mentally ill.

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[2] *Fact Sheet No. 8, Highlights of Recent Community Mental Health, Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, January 1959.*

[3] *Flaschner, F. N.: Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill, Yale Law Journal 56:1178-1209, August 1947.*

Within the frame of civil rights, there are procedures guaranteeing that before any person is deprived of his liberty he is entitled to a judicial determination. But in many states, involuntary hospitalization is available by *ex parte* procedure whereby certification of two physicians is sufficient. There is some doubt about the constitutionality of *ex parte* commitment, which usually requires adequate personal examination, time limits, and, in some instances, notice to relatives or to a state mental health agency. In the over-all assessment, the way to judgment would favor the retention of the *ex parte* procedure as against the more formal judicial determination which, in the light of present psychiatric practices, seems to be over-reaching, unnecessarily burdensome, expensive, and therapeutically handicapping.

Unclarified Issues

Perhaps more formal judicial procedures for involuntary hospitalization would reverse the trend which emphasizes the need to minimize judicial forms of coercion and to encourage maximum participation of the patient in attaining quick recovery. This trend does not touch on the issue of the patient's rights after admission. A beginning has been achieved insuring the patient the rights of communication and protection against unwarranted mechanical restraints; but there remain the unclarified policy issues of the effects of hospitalization on legal capacity, the types of treatment that may be administered without consent, the use of patient-employees without compensation, residential requirements, and the implementation of interstate reciprocity transfer.

It remains to be seen whether or not the legal and psychiatric professions—within the traditional formulae of civil rights—can work out procedures for treating the mentally ill according to the recommendations set forth in the final report. The agenda of the Joint Commission on Mental Illness and Health did not provide for concurrent study of civil rights and law revision. These matters undoubtedly will be attended to in the future by collaboration between lawyers and psychiatrists. •

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1. Morrison, J. E.: Hospitals *33*:97 (July 16) 1959.
2. Laitner, W.: Psychiat. Quart. Suppl. II *29*:190, 1955.

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VII. Psychiatrists Must Give Discriminating Yet Forceful Leadership in Support of a National Program Against Mental Illness

Toward a Fuller Professional Responsibility

By ALFRED H. STANTON, M.D.*
Chairman, Program Committee for 13th Mental Hospital Institute

SOME OF MAN'S SUFFERING IS NOT TO BE BORNE because it need not be.

The published monographs of the Joint Commission on Mental Illness and Health, particularly the final report, *Action for Mental Health,* present clearly the nature and magnitude of the suffering of psychiatrically ill people, and stress that much of it can be alleviated. The Commission and its work were authorized by the U. S. Congress in 1955. This group of highly sophisticated scholars took time out from their various careers to make the first genuinely comprehensive survey of our mental health problem, including our current and potential assets for dealing with it, and have presented an appropriate program to Congress.

The sponsoring professional organizations are now in possession of the facts they need and have the potential leadership required to press for action. Many, however, consist primarily of scientists or practitioners accustomed to "neutrality," to "staying out of politics." They will have to expand their vision to respond adequately. Enacting any program involves the likelihood of mistakes, but the worst mistake we could make now would be to respond inadequately. We are not soon likely to have another chance as promising.

This is not to suggest an uncritical response. Professional organizations are expected to be informed and critical, but not to be paralyzed by criticism. These reports are ideal for critical review. They are conveniently documented and addressed to pertinent topics. They are well-organized and interestingly written. Where insufficient information is available on a subject, this fact is highlighted, and a suggestion made as to how additional data may be obtained.

Importance of Institute Discussions

The 13th Mental Hospital Institute is not the only forum where the issues raised by the final report and the monographs will be discussed, but it is called upon to make an important contribution. The final report is to be the central topic for this all-discipline hospital meeting, and it will be mandatory for participants to retain perspective while discussing the issues. Yet action must not be sacrificed because we are "hot for certainties." One of the most important implied findings of the Joint Commission is that we can do something for patients even before we know all the causes of their illness or all the factors active in treatment. Indeed, to await final proof may do our patients great harm; we would then be acting as if we knew that nothing made any difference to the outcome of mental illness.

The summary report, *Action for Mental Health,* upon which most of the discussions will be based, has both the advantages and vulnerabilities of a survey. It

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**From the Department of Neurology and Psychiatry, Harvard Medical School and The Psychiatric Service, McLean Hospital, Belmont, Mass.*

This is the last in a series of pre-Institute orientation articles. The Institute discussions will be based upon the monographs of the Joint Commission on Mental Illness and Health and Action for Mental Health, the final report of the Joint Commission.

describes the total problem tersely, the good with the bad, the successes with the failures, the clearly understood with the obscure, within a compass which permits us an overview.

I will not discuss at length its broad observation that psychiatric services lag behind other medical services because of public and to some extent of professional rejection of the mentally ill. Nor need one review here the fascinating survey of newer types of treatment facilities developing in a few centers in this country or of the valuable contributions of various helping professions. But several particularly pertinent topics call for highlighting in this last review of the final report—the findings and recommendations about manpower shortages, research, and financial support.

Present and Projected Manpower Pool

The manpower issue is clearly of national concern. The report, in considering the shortage of people in the psychiatric field, is also confronted with the shortage of other physicians, of nurses, of social workers, and of psychologists. It examines the total manpower pool for coming generations and criticizes educational policies that lose our most promising students in high school.

Difficult issues abound in this area. The report recommends the use of nonmedical and nontechnical personnel for psychotherapy, while clearly recognizing recent interprofessional struggles. In the light of the Gargantuan shortage in manpower described in the report, the struggles seem almost Lilliputian. The Commission does insist, however, that psychotherapy be carried out under the auspices of recognized mental health agencies. But it gives little consideration to the possibility of psychotherapy being harmful, and little explicit exploration of the problems of supervision and training, or of utilizing the nonpsychiatric physician to give psychotherapy.

The factors involved in recruiting personnel are more complex than the over-all picture suggests. For instance, the proportion of medical students electing psychiatry varies from 5 to 50 per cent in different medical schools. Side by side with tendencies to reject the psychotic, there is widespread interest, intellectual and emotional, in psychiatric and psychological matters. We are working in areas where basic methodological and analytic problems are not yet clear, and good medical students are attracted to the difficult. I know of no serious data, but there is a widespread impression that few psychiatrists leave the specialty, while psychiatry receives a fair number of recruits already trained in other specialties.

The Commission believes that research offers the best ultimate hope of coping with a problem which exceeds our present abilities. A crash program is not warranted because we cannot predict with enough certainty which area of research is likely to pay off. Moreover, the manpower shortage is as acute in research as in clinical areas. The report gives a stark picture of the activities of psychiatrists in research. They have been largely replaced by psychologists and other workers in basic sciences.

The total scope of American research efforts is assayed and presented in a correlated form not found elsewhere. Over half of the annual $70 million spent on psychiatric research comes from the federal government; state governments and the pharmaceutical industry account for most of the remainder. Expenditure is concentrated in a few universities and in a relatively small section of the country—the middle Atlantic states and the northeast. Problems of recruitment are augmented by this geographical concentration. The report recommends a research program balanced in subject matter, geographic location, and type of institutional setting. Universities, research institutes, and hospitals should receive flexible, experimental support. The report indicates a need for more long-term positions and programs and for more research centers. It underlines the need for psychiatrists and social workers to take a more active role.

The plea for more education in research highlights a major problem in medical schools and psychiatric hospitals, but the report's emphasis on the need for basic research should be qualified. The terms "applied research" and "clinical research" have become derogatory. The result is paucity of support for "mere" technical, clinical, practical, or public health studies. Except for psychopharmacology studies (dangerously initiated by industry and Congress), clinical studies in for instance, psychotherapy, electric shock, and hospital management are few, and are held in relatively low esteem. Support of basic research should not be emphasized to the extent of crowding out more technical studies. There is really nothing wrong with examining the application of scientific ideas to practical problems!

Certain ethical problems of research deserve examination and are of considerable importance in designing research. Most explicitly, the Nuremburg Code, devised during the recent war-trials, states, among other provisions, that no research shall be done on a human being without his consent. It does not, however, take cognizance of the fact that mentally ill and mentally deficient patients may not be competent to give consent. This consideration is particularly poignant when the researcher is working with a helpless, psychotic patient who may have symptomatic fears of "being used as a guinea pig."

Finances Need Further Discussion

Finally, there is the large problem of financing, which the report tackles straightforwardly. Its recommendations, however, rely almost completely upon government, both state and federal, to meet the needs. It mentions Blue Cross and other insurance plans only cursorily, and ignores the possibility of federal subsidy of hospital insurance plans to cover psychiatric illness. The focus of the report is on the central problem of psychiatry—the large number of the most seriously ill patients now inadequately treated. For this reason, group medicine, in clinic or hospital, is the main interest and the office psychiatrist seems to be treated as if he were lost to the mental health effort, instead of being an active part in it. Persons with some economic means usually get private treatment, and this means a better outlook, especially for schizophrenic patients. Insurance would be one way of making private psychiatric treatment available to more people, without compromising the pluralistic institutional basis of psychiatric development which the report generally recommends. The private patient, whether in the hospital or in the office, is leading from strength in that his relationship to his therapist is voluntary, and he is more likely to be respected as a human being than his less fortunate indigent fellow patient. Perhaps this is one reason why it is easier to recruit men to private psychiatry and why private psychiatrists have made so many significant professional contributions.

Shortcomings of Final Report

A survey should be as complete as possible in its overview, and, for this reason, it is unfortunate that the final documents, for lack of funds, could not adequately cover certain areas, particularly family relationships, the problems of aging, industry, children, military service, delinquency and crime, and alcoholism. In discussing a national program, we must not overlook the field of mental deficiency, with its most promising recent discoveries and their implications, or the need to appraise the widespread use of somatic therapy for outpatients.

The recommendations contained in the final report reflect the scope that the total survey has achieved, and make a real attempt to meet the whole problem. While sometimes sweeping and often controversial, the suggestions are all intrinsically reasonable, well supported, and formulated to meet the problems. Among the recommendations is that Congress appoint a committee of consultants to explore ways of implementing the suggestions. Each member of an interested profession should review them in the light of his detailed knowledge of his own particular circumstances, and accept or amend them so that we may finally offer them to the public backed by a full, expert analysis.

Finally, there is no more need for us to be diffident about dealing with the informed public and with legislative bodies because of our lack of definitive knowledge than there is need for us to cease all therapeutic efforts pending a "major breakthrough." The final report is the combined outcome of Congressional authorization and funds, the work of the various (mostly professional) bodies sponsoring the study, and the ability, industry, and imagination of the staff of the Commission. We have the chance of a generation to enact what is necessary and possible. Final policy is not, nor should it be, in our professional hands. Those who make the policy rely upon us to offer a national program forcefully and discriminatingly. ●

Preview of 13th Mental Hospital Institute

October 16-19, 1961
Sheraton-Fontenelle Hotel
Omaha, Nebraska

THE HEART of the 13th Mental Hospital Institute will consist of 20 workshop-groups, each conducted by an experienced discussion leader. For a day and a half, these groups will consider and report upon the findings and recommendations contained in *Action for Mental Health,* the final report of the Joint Commission on Mental Illness and Health. In plenary session on Thursday morning three psychiatrists, who have not been connected with the Joint Commission, will summarize and evaluate the reports of the workshop-groups.

Orientation Address and Main Theme

On Tuesday morning, October 16, Jack R. Ewalt, M.D., director of the Joint Commission, will deliver the keynote address. This will be followed by an outline of Tuesday's special subtopic "The *Findings* of the Joint Commission," after which participants will join their workshop-groups until lunchtime. During Tuesday afternoon, there will be a break in the main theme, so that participants may attend one of six different special-interest discussions. Wednesday morning will open with a plenary session and an outline of the day's special subtopic, "The *Recommendations of* the Joint Commission," after which workshop-groups will continue their discussions for the rest of the day.

Academic Lecture

On Thursday morning, R. A. Cleghorn, M.D., Professor of Psychiatry at McGill University, Montreal, will deliver the Academic Lecture, "The Expanding Vista in Psychiatric Research." Participants will remain in plenary session to hear Henry W. Brosin, M.D., George Saslow, M.D., and Francis J. Gerty, M.D., comment upon the workshop reports. The Institute will close with a panel discussion on "Federal-State Relations—Formulae for Sharing Costs."

Dinner, Awards, President's Address

On the lighter side, the cocktail party and banquet will be held on Wednesday evening, October 18th. Mathew Ross, M.D., the medical director of the

The Missouri River, one of the nation's principal waterways, bisects a broad landscape near Omaha, Nebraska.

APA, will present the 1961 Achievement Awards, and Robert S. Garber, M.D., chairman of the Advisory Committee of the APA Smith, Kline & French Remotivation Project, will present Remotivation Pins to aides from the Norfolk and Lincoln State Hospitals, Nebraska. Walter E. Barton, M.D., will give the Presidential Address, "Vanishing Americans— Mental Hospital Administrators and Commissioners."

Film Program

The Film Program has been planned and will be presented by the Mental Health Materials Center, consultants to the film service of MHS. As well as the "coffee-and-doughnut programs" on Tuesday, Wednesday, and Thursday mornings before the sessions begin, there will be film programs from 4 p.m. to 5.30 p.m. on Tuesday and Wednesday. The following films will be included: "External Cardiac Massage;" "Open Hospital;" "Emotional Factors in General Practice;" "New Light on Darkness;" "Help Wanted;" "Determination of Criminal Responsibility;" "Understanding Aggression;" "Volunteers in Mental Hospitals;" "A Psychopath" (from "The Disordered Mind"); "Anxiety;" "Medical Uses of Hypnosis."

Local Hospital Visits

Cecil Wittson, M.D., chairman of the Local Arrangements Committee, has planned two hospital-visiting programs. Each will end at the Nebraska Psychiatric Institute with a demonstration of the closed-circuit television teaching program which originated here. Other hospitals to be visited include the Veterans Administration Hospital, Omaha; Saint Bernard's Hospital, Council Bluffs, Iowa; Creighton Memorial Saint Joesph's Hospital, Omaha; and Richard Young Memorial Hospital, Omaha, which is part of the Lutheran Medical Center.

For the Ladies

The Ladies' Committee has planned a program of entertainment, and tickets for the various functions will be on sale near the registration desk. This Committee has compiled a guide to Omaha and its surrounding areas, including names and addresses of good restaurants, and the whereabouts of museums, art galleries, and places of historical and scenic interest. This guide will be available to all registrants and their wives.

Other Professional Meetings

On Sunday and Monday, October 15 and 16, various related professional organizations will hold their special meetings. Business administrators, psychiatric nurses, directors of volunteers, commissioners, mental health associates, and public mental hospital superintendents have already been notified by their respective groups.

The Committees

The Program Committee, under the chairmanship of Alfred H. Stanton, M.D., includes J. J. Blasko, M.D., J. E. Gilbert, M.D., J P. Lambert, M.D., and Mr. J. T. Greco.

Cecil Wittson, M.D., is the chairman of the Local Arrangements Committee, with John Aita, M.D., Thaddeus P. Krush,, M.D., and James Mahoney, M.D.

The Ladies' Committee consists of Mrs. Lavern C. Strough, chairman, with Mrs. Kenneth Muehlig and Mrs. Cecil Wittson.

Those traveling to Omaha for the Institute are reminded that, because of a military exercise, all civilian planes will be grounded from 1 p.m. on Saturday, October 14th, until 1 a.m. on Sunday, October 15th (Eastern Daylight Time). The FAA recommends that passengers check with their airports for local times.

Please bring to the Institute the copy of *Action for Mental Health* which was sent at the time of registration. Those who have not preregistered will receive a copy at the registration desk. An annotated guide to the final report will also be available to assist the workshop-groups.

RECOGNITION AND DEVELOPMENT OF AIDES' POTENTIALS

By PEARL HARRIS, *Psychologist*
and RUSSELL W. JOHNSON, *Psychologist*
Philadelphia General Hospital
Philadelphia, Pennsylvania

We recently established a special program, known as Unit Therapy, in a 24-bed ward in the psychiatric section of this general hospital. The purpose of the program is to provide a therapeutic environment for the patients which is focused around interaction with one another and with all staff members. We also utilize the more formal techniques of ward meetings and group psychotherapy. Initially all the patients were women, but now both sexes are included.

We drew our staff from employees on the psychiatric service who had become accustomed to the usual hierarchy prevailing in any psychiatric facility. We told the newly-assigned aides (by which we mean practical nurses, attendants, and kitchen workers) that we considered them as important in the treatment program as members of the professional staff, adding that they were not simply to carry out orders, but that we expected them to start operating much more independently.

Alas, we succeeded only in producing anxiety in this group of people who regarded our verbal declarations with suspicion. Because we had failed to define precisely their new role in relation to the patients and to the professional staff, they were undecided about how they were expected to relate to anybody in this new situation.

Patients became aware of the role ambiguity and exploited it. They started acting out, and, when an aide stepped in, they depreciated his role and threatened to report him to somebody who, within the old hierarchy, would have been higher up. They played one staff member against another until, despite all our reassurance, the aides felt that their positions were tenuous and that any interaction they had with the patients might lead to disciplinary action.

We believed, for instance, that patients would benefit simply by being allowed to express hostility without fear of reprisal. We encouraged them to do so and praised them when they reported such overt expression during group therapy. Neither patients nor aides understood that the therapists' aim was to encourage freedom of thought and expression and were not actually believing the patients' distortions. Aides felt that the professional staff agreed with the disparaging remarks patients were making about them. When they reported their own part in such incidents, the professional staff simply told them that they were "doing fine." They began to think we were double-crossing them.

Believing they were trapped between patients and staff, the aides reacted in various ways. Some withdrew from the patients to avoid becoming targets for abuse; others became involved in angry interactions with patients; still others granted unrealistic favors in an attempt to avoid patients' hostilities. Plainly, the increasing tension demanded that we develop more adequate communications in order to achieve better understanding.

We therefore initiated regular group meetings of the aides with a psychologist who was one of our group therapists. We did not choose a nurse to lead this group because we thought that the aides, versed in traditional lines of authority, might fear reprisals or disfavor if they freely expressed their feelings about patients and staff. We scheduled 45-minute meetings once a week and timed them to overlap day and evening shifts to permit maximum attendance.

From Resistance to Self-realization

Initially, the group members were very cautious and waited for the leader to initiate topics. They might venture a tentative question, such as "What about Joe?" (a patient) without reference to any specific behavior or interaction. They were not yet ready to openly explore their interactions with patients. Some of their reluctance undoubtedly was caused by recollections of other wards on which they had worked where the professional staff, considering a patient's history and problems to be out-of-bounds for aides, censured anyone who expressed interest or curiosity about such matters.

To break down these barriers, the group leader would initiate discussion about the development of the type of behavior he knew Joe commonly displayed. He would talk about similar behavior in normal children and indicate conditions under which such acting-out might be inappropriately continued or intensified during adulthood. If the aides could understand that the patients' strange behavior was not completely removed from that of "normal people" with whom they could empathize, they would no longer regard it as completely "out of this world." This might reduce their ambivalence and perplexity when patients misconstrued their kindly intentions.

During the first two months of the group meetings, an aide and a patient became involved in physical combat. The professional staff, recognizing the patient's extremely provocative behavior, kept the aide on the staff. Group discussion reinforced the concept that aides often could take measures before a patient's behavior developed into an "incident" and emphasized that such behavior was a projection of the patient's underlying problem and was not directed at the aide, personally.

After this episode, the aides felt more secure in their relationships with patients and their trust in other staff members increased. They began to discuss feelings which patients evoked in them and the group meeting became a clearing house for the interpersonal problems which arose out of the intensive daily contacts between staff members and patients. The aides began to understand that a patient's behavior was his way of dealing with a situation and that this was the very problem which had initially brought him into the hospital. When they realized that they, too, could experience mistrust and anger and that professional staff freely admitted to similar reactions, the aides began to have more real empathy with the patients.

Aides Head Meetings

The group meetings have been going on for two years. The aides requested that the head nurse be invited to join, and nurse-aide relationships have progressed so well that all the nurses may participate. The aides' skill in dealing with patients has increased greatly, and recently the professional staff invited several aides to become co-therapists. The aides themselves take turns in leading the group meetings, and the psychologist attends as another staff member and as a resource person who can contribute because of his specialized professional training. New aides readily become part of the group.

We believe that this aide-training program has accomplished its purposes of enhancing staff relationships and thus has created a beneficial atmosphere for the patients. The aides feel free to take part in other staff meetings and offer valuable comments about their observations of the patients. Negative feelings about changing status have given way to recognition of its value by the unit's entire permanent staff. •

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U. S. Psychiatric Centers—Observations and Impressions

By J. A. HARRINGTON, M.D.*
Consultant Psychiatrist and Deputy Medical Director
Ufculme Clinic
Birmingham, England

PERHAPS MY DEEPEST CONVICTION during my visit to the United States was that the National Institute of Mental Health is making a major contribution to psychiatric research. My visit to NIMH in Bethesda, Maryland, was one of the highlights of my tour, and everywhere I went I observed research being pushed forward with vigor under grants from NIMH. Of course, the Institute is fortunate in receiving a large financial appropriation from Congress, and I believe it is making use of its opportunities with intelligence and alacrity.

I was impressed by the freedom granted to research workers to pursue their interests, the lack of political interference in determining the directions of research, and the democratic way in which grants are allocated. Young doctors and scientists are given opportunities to do research without first having to prove their abilities. However, there is a recognized need to sponsor training in research and to provide opportunities for people to enter this field for short periods in order to test their talents for it.

Some Compliments for U. S. Research –

There are, I think, wide variations in the quality of research; its caliber is not correlated by any means with the size of the project. Those concerned realize that research cannot always be expected to "pay off" and that some waste and a willingness to take chances are inevitable ingredients of progress. One well-known psychiatrist, who shares responsibility for the allocation of grants, told me that if they get ten cents' worth of new knowledge out of a dollar spent they are satisfied—a realistic viewpoint.

I was impressed, too, by the amount and quality of some of the research being done independently of the university's academic sphere. I saw some excellent examples of this in research divisions of mental hospitals where work was proceeding rapidly because researchers were free from any direct teaching or clinical service responsibilities. The feasibility of getting a research grant which was not tied to a university faculty struck me as a good thing, particularly for researchers whose personalities and independent views make it difficult for them to fit into the scheme of things in a university department.

Some scientists complained that they had to produce something or perish and that the compulsion to publish had become a national disease. I also encountered the view that uncertainties about renewal of grants and the necessity to meet deadlines for projects created unhealthy anxiety. I do not think that these criticisms are wholly justified, especially since the research grant system allows flexibility so that projects can be abandoned or their direction changed, depending upon the circumstances.

I was particularly interested in observing several attempts at multidisciplinary research; few seemed to have achieved the ideal actuality, but were making real progress toward better understanding between different scientific disciplines attacking the same basic problem. Some centers found it helpful to hold "workshop" conferences in which informal discussions improved communication between different disciplines. I was unable to ascertain how successfully this cross-fertilization produced new ideas, but I did see evidence that theoretical concepts had leaped the barriers of one research discipline into another.

– and Some Criticisms

On the other hand, I saw indications in some centers that bringing unallied research workers together under the same roof had not resulted in better communication; researchers sometimes were almost wholly unaware of what was going on in laboratories other than their own. I felt that this might have been corrected by the creation of a common room for informal social contact—often an absent feature of the researchers' associations.

Perhaps I was most disconcerted by constantly

**From September 22 to December 7, 1960, Dr. Harrington toured the United States and visited many of its mental hospitals. This opportunity was made possible through a grant from the William Waldorf Astor Foundation.*

Dr. Harrington has diplomas in Psychological Medicine (the Commonwealth equivalent of a Board Certification in Psychiatry) and in Public Health. He is affiliated with the University of Birmingham as a Senior Clinical Tutor.

meeting young emigrant research workers, principally Japanese or European, who had received opportunities and support that they failed to find or were unlikely to get at home. Some appeared to be frankly astonished at the speed with which U.S. centers provided the tools of research. They were easy converts to the American concept that all new discoveries are not made in a garret with homemade apparatus and a shoestring budget. I left with the feeling that, although we eventually would benefit from their research, Europe could ill afford to lose such scientific research manpower and remain in the forefront of developments. I reached the inescapable conclusion that research in psychiatry is more highly esteemed in the U.S.A. than abroad.

In general, comparing American and British approaches to teaching psychiatry was a rather humiliating exercise. At times I felt that, over-all, we were as much as 20 years behind in training, and I experienced some embarrassment when explaining how slow we had been in developing our teaching programs. I found that the administrators of most U.S. teaching centers realized the primary importance of training and that everything else ultimately depended upon it. They take teaching seriously, emphasizing modern nondidactic approaches and practical case supervision.

Broad Medical School Curricula

It was a novel experience to find medical schools giving as much time and emphasis to psychology and sociology as to anatomy and physiology in the preclinical curriculum. I did not see a single teaching center where medical students are not exposed constantly to graduate psychiatric teaching. Likewise, postgraduate resident training programs in psychiatry are uniformly better organized and carried out than they are in Britain where often only lip service is paid to teaching junior psychiatrists. Resident training programs seem to be more strictly supervised than in Britain, and hospitals are forced to provide for adequate junior staff who wish to obtain a specialist qualification.

My main criticism of the teaching is that it seems to overemphasize the psychoanalytical viewpoint at the expense of other theoretical approaches and practical methods of treatment. One of the undesirable consequences of this emphasis is the creation of a too-uniform model to which the students aspire. Training is directed towards private psychoanalytic practice which, some people admitted, can fill the therapeutic needs of only a small number of patients. A leading American psychiatrist told me he hoped to secure a revision of requirements in resident training programs which would encourage more young psychiatrists to enter rapidly developing community psychiatric services.

Staff members at several U.S. medical centers expressed alarm, not so much about the current shortage of doctors in general and psychiatrists in particular, but about the calculated future deficit of medical personnel to fill the needs of an expanding population. Plans are progressing to add extensions to existing medical schools and to build some 10 new schools. The planners anticipate difficulty in staffing these new schools with capable teachers.

I encountered medical educators who discussed the decreasing standard of medical school applicants; the most famous medical centers seem to have no real lack of applicants, but this is not the case in the newer medical schools in the Middle West and West. The educators told me that some universities are more or less forced to take students of lesser ability who would not have been considered for entrance to medical school some years ago. The explanation for this is that many able students are attracted by the basic sciences and industry, believing that the medical profession does not have the status and esteem today that it once enjoyed.

Differences in Staffing Structures

Some of my hosts alluded to current staff shortages (psychiatrists, nursing staff, and ancillary personnel), but it was clear that staffing in many psychiatric centers, particularly with regard to psychiatrists, was lavish when compared with Britain.

Emphasis on individual, psychoanalytically oriented psychotherapy in America dictates a different staffing structure than that generally found in Britain where long-term individual therapy is carried out only on a very limited scale. From what I saw and heard, staffing problems in state mental hospitals are entirely different from those in private hospitals; in many cases, state hospitals are short of doctors and must rely heavily on emigrant doctors who are not state-registered medical practitioners. Difficulties arise because many of these doctors have poor command of the English language and little knowledge of American culture—deficiencies that create a greater problem in psychiatry than in other branches of medicine.

Because of a lack of medical reciprocity between the U.S.A. and other countries, as well as between states, the problem of requalification for the emigrant psychiatrists is a real one. Recent regulations may make it impossible for some foreign-born doctors to continue working in state mental hospitals. One psychiatrist told me that reversal of these regulations is almost inevitable because they are creating a serious problem in state hospitals.[1]

My over-all impression of the recruitment of psychiatrists is that this specialty is getting a fairer share of the better medical graduates than in Britain. It seems to me that the U.S.A.'s problem is not how to train more psychiatrists, but to get the existing ones to practice where they are needed most.

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[1] *Since Dr. Harrington's visit, through the efforts of the APA Ad Hoc Committee on the Educational Council for Foreign Medical Graduates, no action will be taken until 1962 against hospitals employing foreign-trained psychiatrists. At the moment, any foreign-trained doctor who is properly licensed or certified is exempt from the ECFMG examination. The Committee considers it unlikely that there will be any significant change in the present ECFMG regulations.*

One cannot help but be struck by the differences in the American and English systems of psychiatric nursing. In some of the well-known psychiatric centers I visited, there was a very high standard of nursing care, which contrasted strongly with what I saw in some of the smaller psychiatric hospitals and state mental hospitals. The highly trained American nurse who holds a university degree often occupies an administrative role and has little practical contact with the patients; she also seems to have some functions which, in England, would be regarded as those of the psychiatrist. Customary "glassed-in" nursing stations on psychiatric wards seem to encourage the nursing staff in some places to observe the patients without actually getting into contact with them.

A great deal of actual psychiatric nursing is done by aides whose skill, I was told, varies considerably. But these aides often are the hospital's most frequent and direct link with patients. I learned of plans to develop more training to improve the skills of psychiatric aides.

One hospital has abolished nurses' uniforms; all staff wear mufti so that they are indistinguishable from the patients, who share in all staff amenities. This undoubtedly breaks down some of the staff-patient barriers, but also creates new problems by confusing identities and roles.

Opinions on Patient-government

Systems of patient democracy, practiced in several centers, did not strike me as wholly good when carried to extremes, although excellent when following a moderate course. One hospital adopted an extreme form of patient-government and later abandoned it because efficiency suffered, the wards became dirty, and grandiose paranoid patients took control and ordered the staff to do things which were clearly not in the interest of the therapeutic community the management was trying to create. On the other hand, I observed that, in one hospital, an authoritarian, heirarchical nursing system and medical administration had encouraged regression of patients who were given little responsibility for themselves and had no sense of individuality or status.

During my visits, I found some confirmation of the opinion I had heard expressed previously in England: that psychiatry had gained far more academic and public acceptance in the U.S.A. than in Britain. Nevertheless, several American sources intimated that mental health had been oversold in advance of knowledge and that disillusionment might ensue if practical results in terms of reduced morbidity and disability are not readily forthcoming.

In my limited contact with the American general public, I was struck by the use of psychoanalytical terms in everyday language and a degree of psychological self-awareness that might not have been regarded as desirable in England. However, my sample was so limited that any conclusion is unwarranted. I could not evaluate the public's attitude toward psychiatry, but was impressed because the publicity given to mental health had inspired widespread activity among volunteer organizations which support schemes to deal with the problems of mental illness.

Psychiatry's Boundaries Confused

I have the general impression that some confusion exists regarding psychiatry's boundaries and who, for example, is to be regarded as sick and who is to be regarded as well. I was surprised to find at one center that British criteria for the need for active therapy are in the U.S.A. indications that the patient is too sick to be treated intensively; exceptions to this are centers where long-term analytical therapy of schizophrenics is undertaken with an expenditure of time and energy that generally would not be thought justifiable in Britain. Exposure to such views certainly gave me food for thought.

I encountered a number of problems that have their direct counterpart in Britain. The overlapping of professional roles between psychiatrists, psychologists, social workers, and nurses seemed a somewhat greater problem than it does here. The need to define professional roles in functional terms is recognized, but administrative solutions are lacking, and people of different professional training appear to be over-aware of their roles as individual psychotherapists at the expense of the special function for which they are trained. I was also faced with the revolutionary but minority opinion that psychiatry should be divorced from medicine and that a new profession of "psychotherapist" be created with an essentially nonbiological training.

I listened to another disconcerting viewpoint—the thesis that no really effective treatment lies between lengthy individual analytic psychotherapy and prevention. However, I did find a good deal of sympathy for short-term and group psychotherapy and physical treatment, although these were generally regarded as second-best, inferior forms of treatment.

The breadth of view and eclecticism of some psychoanalysts impressed me, probably because I had not expected it. In some psychotherapeutic circles, I also sensed the winds of change, expressed in dissatisfaction with over-all results of analytic treatment and desire to examine other approaches. As in England, rivalry between neo-Freudian psychoanalytic schools did not strike me as particularly healthy or productive.

International Nomenclature Desirable

The use of the APA system of classification, rather than the international nomenclature, creates difficulties in communication between research workers in Europe and America. In the clinical conferences I attended, I found more interest in mental mechanisms than in diagnostic classification and sometimes had difficulty in obtaining operational definition of terms. I was disappointed to find little interest in the problems of psychiatric nosography.

Almost everywhere I went I found a higher standard of case recording and clinical and research documentation than is found in England. Some records seemed unnecessarily detailed, but the ready availability of IBM statistical machines and computors is an important development and permits researchers to undertake projects which would have been impossible without such facilities.

A belief in the reality or near-reality of preventive psychiatry was, I thought, more prevalent in the U.S.A. than in Britain. Such views were not held uncritically, and I observed a number of research projects designed to measure the effects of community mental health programs. I left many centers impressed with the fact that they were attempting an objective evaluation of their new experiments in social psychiatry. I found much admiration for similar experiments in England, but could not rebut the criticism that too often they had not been the subject of evaluative research. It was most interesting to see how Americans are attempting to tackle the difficult problem of methodology in social psychiatric research. •

"Drive-in" Nursing Assignments

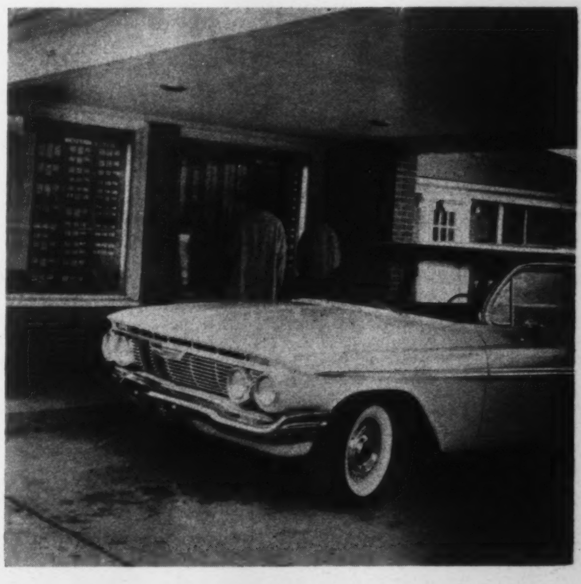
By H. C. PEIPENBRINK, M.S.H.A.
Assistant Superintendent
Manteno State Hospital, Illinois

Nursing service personnel at Manteno State Hospital now check their day's job assignment at a drive-in facility converted at very low cost from an employee housing unit. The chief nurse, who has her office here, posts daily job assignments on a bulletin board without having to leave the building.

Since nearly all of our employees drive to work, the drive-in eliminates the tremendous traffic jam which used to occur three times a day outside the administration building. Some 200 people vainly sought parking space so that they could go inside to discover to which of 67 ward buildings they were assigned.

During the conversion, done by the hospital maintenance department, the original house windows were replaced by two 5′ x 6′ tinted thermopanes, and the roof was extended over a 26′ concrete drive to give shelter during inclement weather and to keep the thermopane clear of snow or condensation. Inside the thermopane, we installed metal-covered plywood doors which completely covered the inside of the windows and painted them flat green to eliminate glare. Between the thermopane and door is a 6″ boxed-in space; fluorescent lights on all four sides illuminate the board for night use.

The name of the ward, the employee, and other needed information is typed on index paper, which is inserted into clear plastic card-holders. These are fastened to heavy duty Alinco magnets, 1″ long by 3/8″ wide and 3/16″ thick, which hold firmly to the metal-covered doors. These card-holders are placed between narrow painted vertical lines; day-to-day changes are easily made by replacing the magnetized card-holders. The magnets also are effective to hold paper notices on any portion of the board not in use for assignment purposes.



Have You Heard?

EMPLOYMENT OF MENTALLY DEFICIENT CHILDREN—Boys and girls from the Harrow De Groot School in Regina, Saskatchewan, Canada, are doing useful work for the Saskatchewan Treasury Department. Every month they stuff $500,000 worth of public assistance checks into envelopes for mailing to recipients. The checks must be matched with the right envelopes, and, according to the deputy provincial treasurer, mistakes are uncommon.

In the spring of 1960, the same group stuffed accident-prevention messages into envelopes bearing 23,000 utility bills—the children's contribution to Saskatchewan's sixth annual Child Safety Day.

CENTER FOR EMOTIONALLY DISTURBED CHILDREN—Governor Rockefeller of New York has announced plans for conversion and expansion of the Fairmount Division of Syracuse State School into a residential center for emotionally disturbed children. The center will be used for treatment, research, and experimental and demonstration purposes. It will operate in connection with Syracuse Psychiatric Hospital, the Upstate Medical Center of the State University in Syracuse, and Syracuse University. The governor indicated that Syracuse State School eventually will be discontinued and that Fairmount's mentally deficient patients can be accommodated in other facilities. The state's communities are now providing increasing educational opportunities for the mentally deficient. Institutionalization, solely for education purposes, is no longer considered necessary or desirable for such children.

GENERAL PRACTITIONER SEMINARS—Friends Hospital, Philadelphia, Pa., is offering a series of five seminars on "Psychiatric Problems of Particular Interest to the General Practitioners," sponsored by the Philadelphia Academy of General Practice. The American Academy of General Practice is awarding formal credit in Category I for attendance.

Seminar topics include "The Recognition of Incipient Mental Illness," "The Retarded Child and His Parents," "The Adolescent and His School," "Psychiatric Aspects of Medical Hypnosis," "The Management of Grief Reactions," and "Emotional Development and Neurotic Reactions."

IBM CARDS FOR PATIENTS' STATISTICS—Milledgeville State Hospital, Milledgeville, Ga., now has an IBM punch-card system for patients' statistics. The new system will serve the following purposes: to provide current, adequate, and accurate statistical information on patients as required for administrative purposes; to serve as a basis for research; and to integrate requirements of the NIMH's Model Reporting Area for Mental Hospital Statistics with Milledgeville State Hospital's requirements, so that data for both state and nationwide purposes will be collected in one operation.

BOOK REVIEWS—The professional staff of the VA Hospital, Topeka, Kans., prepares reviews of technical books which are of interest to hospital personnel. The reviews are published under the sponsorship of the Medical Library Committee and are compiled in the Office of the Chief Librarian with assistance from the industrial therapy program.

Volume 2, Number 2 of *Book Reviews,* published in June 1961, contains 10 reviews. Among the books reviewed are *The Biological, Sociological and Psychological Aspects of Aging by Kurt Wolff,* M.D.; *William James on Psychical Research,* compiled and edited by Gardner Murphy and Robert O. Ballou; and *Internal Medicine: A Physiologic and Clinical Approach to Disease* by Robert P. McCombs.

WORK THERAPY—A new work-therapy program to help selected psychiatric patients "earn" their way back to productive living was begun at the day center of the outpatient clinic at the Veterans Administration Regional Office in New York City.

Patients are paid wages for their work, which consists of assembling pens, necklaces, and other items for local manufacturers. Wages are not the main objective of the program, but serve as a motivating force. This type of therapy simulates actual industrial conditions, making the transition to a real job much easier for the patients. According to the clinic's director, Dr. Sylvan A. Frankenthaler, the work is proving to be a valuable form of therapy and has been received with enthusiasm by the veterans.

TEACHER WORKSHOPS—The Division of Community Services, Kentucky Department of Mental Health, held two teacher workshops in mental health during the past summer. The workshops were designed to help teachers understand mental health principles and included discussions of personality growth and development, parent-child-teacher relationships, and the role of the teacher in the community.

Community leaders, faculty members of Western State and Murray State Colleges, and Division personnel planned and participated in the courses.

CADRE-EMPLOYEE PROGRAM

By PETER A. PEFFER, M.D.
Superintendent
Glenwood State School
Glenwood, Iowa

In developing a total program of education, training, treatment, and habilitation for mental defectives in the institution and in the community, we conceived what we call a "Habilitation Ladder." This ladder has five rungs—the bottom one representing a training program adapted to the lowest-level patient. As the patient masters this training, he is advanced to the next or second-rung program and then to the third rung.

At this point we find that a number of patients level off and can go no higher. The fourth step is habilitation or preliminary preparation for life on the outside. The fifth is the Trainee-Employment Program, patterned after the VA Member-Employee Program for convalescent mental patients.[1]

Therefore, on the habilitation level, we have developed another step called the Cadre-Employee Program. The male or female patients in this program live in separate quarters and work for the hospital a full eight hours a day, six days a week. In return for their services, we provide full maintenance, clothing, medical and dental care, and pay them $16 a month. They may work in any area of the hospital. If special clothing is needed for their work, as in the nursing service, the hospital supplies it. These workers wear a large button with the words "Cadre-Employee" on it.

Cadre-employees receive more or less permanent institutional placements; the hospital will continue to be their "home." They eat at separate tables in the patients' dining room and these tables are made as attractive as possible. Their quarters, likewise, are well decorated and comfortable.

Cadre-employees have privilege cards which list privileges commensurate with their ability. Some may go to the local town to shop. Others, because of certain problems, may not leave the institution unless escorted by one of the vocational trainers.

The school's vocational habilitation department directs the work of the cadre-employees, makes job assignments, insures attention to duty, looks after the payroll, administers discipline, etc. The nursing service manages the living quarters, and a physician from one of the four area therapeutic teams gives any needed medical care or treatment. The selection of patients for this program is made by the therapeutic teams.

Course of Instruction

At present, most of the cadre-employees—37—work for the nursing service. They receive a course of instruction, based on that given during the 75-hour attendants' program. Content includes the use of the telephone in emergencies; helping the patients with baths, showers, and oral hygiene; supervising their handwashing; bedmaking (occupied or unoccupied); helping patients care for their feet, hands, and nails; giving them shampoos; giving them backcare; serving food to the bedridden; looking after incontinent patients; lifting bedridden patients (with or without a special lifting device); and housekeeping, including the elimination of pests, dusting and cleaning, checking light bulbs, evacuating wards in case of emergency, checking linen, etc.

We also assign cadre-employees to the food service department, to the laundry, and as helpers in the

---

**Dr. Peffer is now superintendent of Paul A. Dever School at Taunton, Massachusetts.*

[1] *Employment Plan for Patients Leads to Later Job Placement, Mental Hospitals 4(7):7, Sept. 1953.*

engineering department. One runs our linen and clothing exchange.

Cadre-employees remain in the program for a minimum of two years. Some will be there for life, but others may be able to go up the habilitation ladder and become trainee-employees. Still others may even be placed in jobs outside the institution and live in the community. We now have 57 cadre-employees and ultimately expect to have 100 to 120.

Potential Applications of Program

The main value of the cadre-employee program is to give the middle-functioning mental defective something to aspire to. In the program, he may acquire some of the status and prestige we all need and be a contributing member of society within a safely sheltered setting. This is a milestone for such patients whose IQ's average about 40 or slightly above.

Cadre-employee programs are equally applicable to chronic psychiatric patients for whom discharge is an unrealistic hope. Numbers of them can do excellent jobs in the hospital, but will probably never be able to maintain themselves in the community. In addition, each state could develop cadre-programs of mentally deficient patients, who could assist in the work of their own institution or in one of the state's mental hospitals. ●

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GLOSSOVER GLOSSARY

"Leave other people to discover what it is that you have said; and as their minds are slow, you can make your escape in time." Schopenhauer, *Counsels and Maxims.*

Psychiatric Conversations

	PHRASE	MEANING
1.	(Progress Note) The patient has difficulties with interpersonal relations.	He argued with the psychiatric consultant.
2.	We will have to increase the patient's medication.	He refused to go to his work detail this morning.
3.	(Said to patient) We're all professional people here, members of the staff. . . .	—now, about your sex life . . .
4.	(Said to patient) You've got to prove yourself.	Like, make everybody happy . . . especially your doctor, your wife, and your ward supervisor.
5.	(Progress Note) This patient is quiet and cooperative.	It's a pleasure having him on the ward. We hardly know he's around.
6.	The patient is improving.	He's beginning to think like his therapist.
7.	You've got to keep roles well defined.	What do you mean—the housekeeper is doing *therapy?*
8.	(Said to patient) You've got to learn to accept reality.	Don't bother me; I have my own problems.

George G. Katz, Ph.D.
Staff Psychologist
VA Hospital
Downey, Illinois

Patients Enjoy "Special Meals"

By LOUISE HICKS
Food Administrator
Agnews State Hospital
San Jose, California

OPERATING A GOOD BASIC FEEDING PROGRAM in a large hospital demands the constant efforts of the food service personnel, the service's effective participation in the industrial therapy program, and the interest of the entire hospital. In addition, we have found at Agnews that a "special meals" program can really sell the food service to patients. Special meals give the patient an opportunity to choose what he wants to eat and benefit him therapeutically by making him feel that this meal is planned especially for him.

In setting up our program, we were careful to consider several important factors: (1) minimum staffing with maximum patient help; (2) 29 dining areas that serve a gamut of general, geriatric, and therapeutic diets; and (3) the necessary approval and cooperation of the medical and nursing services' personnel.

We began our special meals program in June 1960 with a cold smorgasbord—a choice of two meats (usually roast beef or sandwich meat), cheese, assorted relishes, deviled eggs, spiced beets, tossed salad, hot rolls, ice cream sundaes, and a choice of beverages. At first, we had to follow a standard menu which prevented geriatric and therapeutic-diet patients from enjoying special meals, but the other patients responded to them enthusiastically. Many patients thought we were celebrating someone's birthday or a holiday.

Next, we started a series of special hot buffets which lasted from February to May in 1961. Again, we followed a standard menu: swiss steak, whipped potatoes, spring beans with bacon, assorted relishes, fruit gelatin salad and colored mayonnaise, hot holls and whipped butter, cherry tarts, coffee, and milk. This time, geriatric patients could participate by substituting diced swiss steak and refusing the relishes. Other types of therapeutic-diet patients could eat the same basic meal with minor changes. After a little juggling we were able to include 200 geriatric and 200 therapeutic-diet patients. Altogether, 3,350 patients out of a total population of 4,150 enjoyed these meals.

Since Agnews is divided almost in half and the east side is about three miles from the west side, we have two complete central food areas, each geared to serve 3,000 people. Each Thursday we served hot buffets in both areas. Food personnel from east and west soon began to compete with each other to offer more beautifully decorated food dishes. The dining rooms reflected heavy competition in decorating for holidays such as Washington's Birthday, St. Patrick's Day, and Easter. The hospital volunteer services furnished floral centerpieces, place mats, and linen tablecloths. Patients, volunteers, nursing and medical services' personnel cooperated with food service to make these meals a success.

The response to the buffets overwhelmed us. Patients with grounds privileges visited the food administrator's office to express their appreciation and say how much the buffets meant to them and to their friends. We still receive letters and phone calls from employees as well as ex-patients.

Last summer, during smorgasbord "season," we added a new cookout program. After obtaining four portable braziers, we notified ward personnel that they could start scheduling cookouts as often as they had personnel to run them. The nursing personnel handled this program exclusively. They used the daily menu unless the food could not be cooked outside, in which case they served hamburgers or hot dogs. Several ward groups held cookouts in nearby parks or at the beach.

Special meals cause additional work for food personnel, but are also a pleasant diversion from regular institutional cooking. Preparing a variety of foods for the special meals actually improved daily food preparation and service. Patients recall the meals with pleasure, and food personnel strive constantly to better the menu in both concept and preparation. •

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References: 1. Cameron, E.: Canad. Psychiat. A. J., Special Supplement 4:S160, 1959. 2. Christe, P.: Schweiz. med. Wchnschr. 90:586, 1960. 3. Schmied, J., and Ziegler, A.: Praxis 49:472, 1960.

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This is the first supplement ever to be included in a regular issue of MENTAL HOSPITALS, *and consists of papers presented during a symposium held on June 24, 1961, at the Institute of the Pennsylvania Hospital, Philadelphia. The editor is indebted to Lauren H. Smith, M.D., Physician-in-Chief, for the use of this material. The material is published here so that the papers and discussions may have the widest possible circulation and readership in public and private psychiatric hospitals and the psychiatric services in general hospitals.*

OPEN STAFFS

In Psychiatric Hospitals And Services

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OPEN STAFFS IN PSYCHIATRIC HOSPITALS AND SERVICES

INTRODUCTION

LAUREN H. SMITH, M.D.
Physician-inChief, Institute of the Pennsylvania Hospital Philadelphia, Pennsylvania

The focus of this meeting was on a little-tried concept in the care of the mentally ill, namely, the creation in psychiatric hospitals of open-staff privileges similar to those that referring physicians enjoy in general hospitals. This plan is variously named "open-staff hospital," "attending-staff program," "courtesy staff" and so on.

For the purpose of discussion, we will define the "open-staff hospital" as one that, like the Institute of the Pennsylvania Hospital, organizes an attending staff of private-practice psychiatrists as active, associate, or courtesy staff members, who may enter the hospital and participate with full- or part-time members in treating patients. In some instances, such attending physicians assume full professional responsibility for the care and treatment of their patients.

This is an organization pattern similar to that common in general hospitals whereby medical and surgical practitioners and various specialists may bring in their patients and treat them in return for which they give some free service to the hospital. It is not, of course, quite correct to refer to the attending physicians as an "open staff" because an organized attending staff is really a closed one, but it is open in the sense that a private physician may become a member of the attending staff, if he is qualified, and receive hospital rights and privileges in exchange for some service to the hospital.

In psychiatric hospitals, there is another facet to the program—the admittance of nonpsychiatrists to attending-staff privileges. One vital question, raised in the final report of the Joint Commission on Mental Illness and Health in a discussion of our psychiatric manpower shortage, is whether qualified general practitioners and other qualified nonpsychiatric physicians could and should assume some responsibility for meeting the psychiatric needs of the community.

Interest in this topic was so great that 127 people from 114 hospitals and agencies in 26 different states attended the one-day symposium held on Saturday, June 24, 1961, at the Institute of the Pennsylvania Hospital. I believe that this meeting will prove to be as historically important as was the First Mental Hospital Institute held here in April 1949.

Special Acknowledgment

I must pay special tribute to the Smith Kline and French Laboratories whose financial support, in the form of a special grant, has covered all the expenses involved in this meeting and a portion of the cost of publishing the material in this special supplement to *Mental Hospitals*.

EXPERIENCES AT THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL

PRESENTATION BY A STAFF PSYCHIATRIST*

J. MARTIN MYERS, M.D.
Executive Medical Officer
North Building Service
Institute of the Pennsylvania Hospital
Philadelphia, Pennsylvania

Hospital settings vary so widely that their programs can be evaluated only in relation to their facilities. The Institute of Pennsylvania Hospital, for instance, is the psychiatric division of the nation's oldest (1751) general hospital, but is located five miles away from the main hospital. It consists of two inpatient sections. The 102-bed Center Building Service is a completely open facility and has no legal authority to detain a patient. The North Building Service has 153 beds and is licensed by the Mental Health Act of Pennsylvania to receive, treat, and detain the mentally ill—by commitment if necessary. The legal responsibility for treatment is fixed upon the Institute's physician-in-chief, Dr. Lauren H. Smith.

Forty-five psychiatrists have their offices in these two buildings, but 89 private psychiatrists are privileged to admit and treat their patients in the Institute. This arrangement was formalized in 1957 by organizing these physicians into an attending staff. In 1936 only five private psychiatrists brought patients into the hospital; by 1950 about 40 used this privilege, and last year 82 different psychiatrists (mainly but not exclusively members of the organized attending staff) treated their patients here.

On the Center Building Service, the attending psychiatrists determine and control their patients' treatment. The hospital provides nonmedical services, such as room and board, general nursing service, occupational and recreational therapies. One staff psychiatrist devotes part of his time to supervising these services, and may advise the attending psychiatrist if one of his patients is too disturbing to the rest of the group. Personnel in training have little contact with the patients. The service is analogous in every way to a private medical ward in a general hospital.

The complex relationships involved between a regular and an attending staff, therefore, are best illustrated on our North Building Service. Here the hospital staff consists of four senior psychiatrists, plus 14 first- and second-year residents. At the time of admission, each patient is assigned to a resident who is responsible for the initial work-up, and also for the treatment program under the supervision and delegated authority of the full-time staff. Only the resident writes orders, except in an emergency. The patient's attending physician shares the treatment supervision, and the resident must contact him immediately after the patient's admission to learn of his plans. The resident has the continuing responsibility of integrating the thoughts, plans, and wishes of the attending physician and the hospital staff. He reports any divergence of opinion to a senior staff member of the hospital who takes it up with the attending physician. In case of complete disagreement, the hospital staff has the legal responsibility, but, in practice, our staff psychiatrists are flexible people, and usually agree to any accepted treatment modality even if, in their opinion, a different form of treatment seems preferable.

Advantages

A continuing doctor-patient relationship is valued by psychiatrists as being of paramount importance in psychotherapy, even when somatic modalities are being used. An open-staff policy affords the patient this advantage. Psychiatric hospitalization is only part of a longitudinal treatment program, which does not begin when the patient is admitted any more than it ends when he leaves. The physician who knows that hospitalization is accepted as a segment of total treatment and is easily available when the patient needs it will not recommend it prematurely, nor take an unwarranted risk by delaying it too long in order to maintain his relationship with his patient. He can use the special techniques and facilities avail-

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**This presentation was based on an original paper "Attending Physicians for the Psychiatric Hospital (Open Door Policy)" published in Comprehensive Psychiatry, Vol. II, No. 3, June 1961.*

able in the psychiatric hospital precisely when his patient needs them most.

Hospitalization will be briefer and will cost the paying or insured patient less when his own psychiatrist can supervise his treatment. Without the attending physician's evaluation, the work-up takes two or three weeks, and treatment can only start after this. With the use of the referring doctor's evaluation, treatment can begin at once, so that the patient may be able to leave the hospital earlier. The recent one-day admission of a chronic schizophrenic patient illustrates this: He had been under private treatment with drugs and psychotherapy for several months, but, in an acute exacerbation, he attempted suicide in his apartment one Sunday afternoon. His psychiatrist referred him to the Institute on emergency 21-day papers. The next day, the same physician decided that discharge and return to work would be best for the patient's long-term benefit. This calculated risk could be taken only because the private psychiatrist's judgment could be used, and the hospital staff didn't have to make a separate evaluation of the risks and benefits involved. The patient spent 18 hours in the hospital; he lost only one day of work.

With an attending staff, the administrative and therapeutic roles of physicians dealing with the patient can be clear and uncomplicated. If desirable, the attending physician can emphasize his position as helper and therapist, while the hospital psychiatrist naturally falls into a more authoritarian position, receiving the negative transference while the attending physician receives the positive. (Some hospitals achieve the same end by designating one staff member as therapist, and another as administrator.)

The utilization of attending psychiatrists can help provide more skilled or specialized treatment than could be provided by the hospital staff alone. The patient is more likely to get better psychotherapy from a senior psychiatrist than from a young resident. Moreover, an outside psychiatrist is especially oriented toward his patient; he is constantly striving to individualize his treatment, to prevent his patient from getting lost in a group, and to demand that the hospital staff continually evaluate its policies. Despite therapeutic communities and patient councils, the patient is more readily heard when his physician is speaking for him.

The more open the hospital staff, the less likely it is that a party-line will develop about therapeutic modalities. At our present stage of knowledge, the narrowing of professional approaches seems undesirable. Cross-fertilization is important to the treatment of patients and to the training and development of psychiatrists. Numerous attending physicians expose residents to varying attitudes and treatment philosophies. The more outside doctors come into the hospital, the wider will be the learning experiences of the residents, who will be able to assess the value of different approaches to different patients and situations and mature professionally more rapidly.

Disadvantages

The addition of outside physicians unquestionably increases problems of communication. This is perhaps the main disadvantage of an open staff. The variations in viewpoint about treatment held by staff members and attending physicians may provoke a great deal of anxiety in the patients, their families, and the hospital personnel, especially the younger, inexperienced and less secure residents and nurses. Patients and families are quick to pick up real or apparent inconsistencies, and will often use slightly different statements, opinions, and attitudes in a very hostile way.

Residents in the early stages of their training are discomforted to learn from older practitioners that there are several different ways of dealing with the same problem. Hospital staff, charged with legal responsibility for the patients, become anxious and frustrated trying to run a service which must meet the needs not only of 150 patients, but also of 89 different physicians. When such anxiety provokes inconsistency—as differentiated from flexibility—in handling a patient, the patient's attempts at recovery may be deterred.

Practical problems will sometimes arise because an attending psychiatrist is so oriented toward his own patient that he forgets the welfare of other patients on the floor. One such physician, wanting his patient to have the responsibility of taking his own medication, sent him back to the floor with the drugs without thinking about the danger to several highly suicidal fellow patients. This was simply a lapse of memory, but a more frequent problem is the physician's demand for special attention or privileges for an individual patient. Here the staff's judgment of total patient-care must be operative, but the difference can usually be settled by a telephone discussion. Decisions involving groups of patients sometimes disturb the private psychiatrist, especially if he thinks they impinge upon his treatment plan. An example is the physician who objects to his patient being subjected to additional venipunctures when all patients on the ward are part of a research project of which this is one procedure.

Training occasionally suffers because the outside physician wishes to limit the resident's involvement with the patient and hence, of course, his learning experience. Fortunately, such prohibitions are infrequent, and can be offset by additional precepting outside the scheduled hours.

A final disadvantage—and this is a human reaction felt by all of us on the hospital staff—we can't always have our own way! •

PRESENTATION BY AN ATTENDING PSYCHIATRIST

KENNETH E. APPEL, M.D.*
Professor of Psychiatry
University of Pennsylvania
Medical School
Philadelphia, Pennsylvania

DURING THE PAST SEVERAL DECADES, the practice of psychiatry has changed greatly. It has become community-related; it is doing a better job and making more use of collaborative personnel. Yet the physical and mathematical sciences have advanced more rapidly than the behavioral and social sciences, although, as so many critics of society have indicated, the most crucial questions facing mankind today involve psychological and social conduct. These are problems for us as psychiatrists and, of course, for our psychiatric hospitals.

Two main factors have contributed to the community demands upon psychiatry. The first was psychoanalysis, which brought therapeutic optimism, emphasizing as it did the psychological factors in the etiology and treatment of emotional and mental disturbances, and the possibility of effective intensive treatment by community private practitioners. The second relatively recent factor was the advent of the tranquilizers, which, by reducing malignant anxiety, make it possible for psychiatrists to give guidance and psychotherapy to patients in the community who formerly would have required hospitalization.

As to the greater effectiveness of psychiatry, the figures speak for themselves: 29 days is the median stay at the Institute of the Pennsylvania Hospital—this is brief indeed for a psychiatric illness. Other hospitals with excellent facilities report discharge rates of between 70 and 85 per cent, and, in 1959, for the first time in history, the resident population of public psychiatric hospitals showed a small, but definite decrease. This means that more patients returned home quickly, showing great improvement after short, intensive hospital treatment.

As psychiatry's competence has grown, the demands upon it have increased and its responsibilities have broadened. These things, together with our rapidly increasing population, have made our existing manpower and our manpower potential insufficient. Moreover, manpower will probably worsen. We already are aware of the inadequacy of our facilities to deal with the social and personal tensions and the psychiatric breakdowns in the general population. Fewer young people choose medicine, with its long and expensive training, as a career, and relatively fewer young doctors are willing to spend the additional years needed to specialize in psychiatry. The Joint Commission on Mental Illness and Health, taking cognizance of these trends, recommends that we explore the possibilities of making better use of available facilities and manpower. One of the purposes of this symposium is to examine ways whereby the private practitioner in psychiatry can be induced to devote some of his talents to public psychiatry and to the hospitalized, psychotic patient, rather than to continue confining his activities to the less sick —the profitable, the amenable, the convenient, the neurotic patient.

Dr. Lauren Smith in his paper "New Horizons in Psychiatric Hospitalization" calls attention to our need to develop new ways of using private psychiatrists. "All qualified physicians must fully participate in hospital treatment as well as home treatment," he writes. "In psychiatric hospitals, staff relationships, like those now characteristic of general hospitals, should be provided for state mental hospitals and veterans' hospitals. The staff organization now existing should add open-staff privileges to qualified psychiatrists and general practitioners. These visiting physicians should be allowed privileges of sharing responsibility for therapy."

Legal and Medical Responsibility

These are challenging statements. How open can a psychiatric staff be? Both legal and medical responsibilities have to be considered. The general hospital provides the paid staff—interns, residents and some full-time senior staff—but many attending psychiatrists are not on salary. The re-

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**Consultant to the Institute of the Pennsylvania Hospital.*

sponsibility for care and treatment of the patients is vested in the medical director or in the president of the medical staff. If anything goes wrong and there is an accusation of unconventional, unsatisfactory, mistaken treatment procedures, the attending physician, the medical director, and other staff doctors may be sued. Many patients, who formerly were nonpaying, are insured today and considered to be private or semiprivate patients. This increases the likelihood of litigation.

Psychiatric hospitals are licensed by the state and have salaried administrative staffs. Formerly, patients referred to these hospitals were under the care of the permanent, paid staff. Occasionally, the family physician or the private psychiatrist would visit the patient, talk with the staff member responsible for his care, and perhaps make suggestions about treatment. This was the situation at the Institute several decades ago.

Today, after the permanent staff has approved acceptance of a patient, the treatment program evolves through the collaboration of the permanent and the visiting staff. But this collaboration is a courtesy and a privilege to the attending physician, who maintains a close moral, social, and medical relationship with his hospitalized patient. He visits regularly. In cooperation with the permanent staff, he often supervises the physical, medical, psychological, environmental, and social aspects of the treatment regimen. But ultimately, the permanent staff is medically and legally responsible for the patient.

This kind of arrangement is immensely complicated and requires patient and tactful adjustments on the part of visiting and permanent physicians. Considering the many opportunities for chaos and confusion, it is remarkable how smoothly the Institute program runs. As Dr. Myers has said, "We can't always have our own way—but who can? Certainly not the President of the United States; Hitler had certain limitations imposed upon him, and it is increasingly apparent that Krushchev's power is anything but absolute. Even that independent man—the psychiatrist in private practice—suffers certain pressures that limit his complete freedom to direct his patient's treatment."

Difficulties and Frustrations

As an attending psychiatrist at the Institute, I accept the fact that certain procedures are essential from the point of view of the hospital's administration, its training program, its licensure, and its legal responsibility. Orders, for instance, are written by a staff member—usually a resident. If he disapproves of my recommendation, he will discuss it with me or with his senior on the staff who, in turn, may come to me. This often means delay, differences of opinion, and resistance to the ideas, plans, and wishes of the attending psychiatrist. However, the situation rarely becomes serious, and I have never had to remove a patient from the hospital because of such disagreements or delays. Naturally, irritation and frustration occur occasionally, but such occasions offer the opportunity to exhibit patience and understanding, perhaps to reconsider, and certainly to explain and present the reasons underlying the recommendation. One must deal with one's own feelings—the frustration of therapeutic zeal, one's need for magic, feelings about therapeutic failure, and need for omniscience. Everybody's attitudes toward authority and the ability to deal with it come into play, and there is plenty of room for the stimulation of narcissism in both the administrative and the visiting-staff members.

However, under this collaborative operation, despite the inherent difficulties, the community, the patient, and the family are amply protected. Its results are careful scrutiny, honest justification, and consultation between numerous personnel, especially when the question is one of using an old treatment method or trying something new. Such multiple safeguards are especially valuable to the psychiatric patient whose normal judgment is so modified that he needs guidance and the participation of many others on his return to health.

Personal and Professional Growth

Both visiting and permanent staff benefit from the active communication which is the heart of the North Building Service. The necessity to accept responsibility, to suffer criticism, to explain and interpret one's decision make for maturity of personality and judgment. The patients, the hospital staff, and the visiting physicians are brought closer together, to the benefit of all.

Our procedures call for more refinement, more scrutiny, and more study in order to become more efficient. To my mind, however, the advantages of the open-staff system greatly outweigh the difficulties of its operation. It both protects and challenges the visiting psychiatrists, and enables them to offer more comprehensive treatment through the use of hospital facilities. It is mutually educational to the residents, their seniors, and the visiting staff. It militates against professional isolationism, authoritarianism, and narcissistic attitudes on the part of the administrative staff. The constant interplay of differing viewpoints prevents rigidity and narrowness of therapeutic approach. It protects patients and their families, and offers them the considered judgment of a large number of highly competent people. And by involving community physicians, it keeps psychiatric patients and their treatment close to the community. •

Discussion by Group

Is it likely that differences of opinion between the administrative and the attending staff in a private psychiatric hospital will destroy the staff unity which is needed to establish a therapeutic milieu? The Institute of the Pennsylvania Hospital, suggested some discussants, is really more of a closed-staff hospital because such a large number of the attending psychiatrists actually have offices in the hospital buildings. They doubted whether this particular hospital's experience was applicable to other hospitals.

Another debate concerned the idea that continuity of treatment is always good for the patient. Sometimes a break with the private psychiatrist, as well as with the patient's home community, might be desirable. From the practical point of view, hospitals to which patients come from distant areas cannot function in the same manner as where the patient's own psychiatrist is in the area.

Opinion was divided about the desirability of an attending staff. Some expressed the view that a psychiatric hospital, like any other hospital, simply should provide the usual hospital services and leave all treatment to the referring psychiatrist. Others felt strongly that a closed staff of experienced therapists provides a more uniform and higher quality of psychiatric care.

Another practical consideration is the law of the particular state in which the private psychiatric hospital is situated. In some states, the superintendent is legally responsible for the care of all patients; the wisdom of such laws is questionable. But the legal problems arise mainly because of the difficulty patient and family may have in accepting the need for hospitalization; this difficulty can usually be worked out satisfactorily with the family. Thus the need to legally retain a patient is uncommon.

This group was concerned with the screening of attending psychiatrists to insure a high level of competency. Selection methods suggested included the establishment of a screening committee, personal interview with the private psychiatrist, letters of recommendation from professional colleagues, and a probationary period.

A few financial considerations specifically concern private psychiatric hospitals. Most permit the referring psychiatrist to bill the patient separately for his services; a few have attempted to control the fees, but for the most part, this is a private matter between the psychiatrist and the patient or family. Others will act as a collection agency for the physician.

In no instance does a private hospital reduce the basic rate because the patient retains a private psychiatrist. Many hospitals, however, make a charge for psychotherapy provided by its closed-staff psychiatrists, and this charge may be paid through various insurance plans, including Blue Shield.

Manley Brunt, M.D.
Recorder

EXPERIENCES AT A STATE HOSPITAL

PRESENTATION BY THE SUPERINTENDENT

WALTER E. BARTON, M.D.
Boston State Hospital
Boston, Massachusetts

The attending staff was established at Boston State Hospital in the mid nineteen-forties, in an endeavor to improve a typically bad state hospital situation. Staff had been depleted during the war years, and wartime shortages had resulted in deteriorated buildings. The classification of the patients was political, not psychiatric, and abominable medical techniques actually endangered their lives. The few hospital physicians were isolated from the rest of the medical community, and nobody wanted to train in the atmosphere of frustration and guilt. Salaries were too low to attract new senior staff to the hospital.

We hoped to free the few available psychiatrists from routine medical procedures so that they might give more time to psychiatric treatment.

We asked the District Medical Society if physician-volunteers could help us and received 80 applications for 10 positions. The selected physicians made physical and medical examinations on a fee-for-service basis—$2 each—and most could do eight physicals or eight mentals in two or three hours. This was our original visiting staff, and I reported on its work at the First Mental Hospital Institute in April, 1949.

Next, we established regular diagnostic clinics in each of the medical specialties so that a patient with a draining ear, for example, might be referred to the Eye, Ear, Nose, and Throat Clinic for examination and treatment. The activity of the clinics led to the need for inpatient beds for further medical studies and treatment. We assigned beds to the various specialties, and the chiefs of the attending staffs started making regular ward rounds. All of these changes were valuable in our teaching programs.

Organization of Program

From this beginning, we continued to build our visiting staff. The appointed specialist chiefs recommended physicians to each division, basing the appointments on the physicians' competence, interest, availability, and the regularity with which they could keep scheduled appointments. Each of these associates served for a month. During this time they were responsible for working in the scheduled diagnostic clinics, making ward rounds, teaching, supervising, and attending the various subcommittee meetings.

The chiefs of the major services—medicine, surgery, and psychiatry, together with four elected members of the attending staff—formed our Medical Executive Committee, which disciplined its members to insure sufficient coverage to meet all emergencies and all patient-care problems. It helped to establish rules and regulations, so that, through self-government, a quality medical staff and the best possible treatment were insured. The committee established educational standards, reviewed and evaluated the performance of all staff members, and recommended improvements to the administration. The superintendent and the assistant superintendent are ex-officio members; one of the attending staff members annually rotates off the committee.

We established a Joint Conference Committee—responsible for resolving differences of opinion between members of the Board of Trustees—and subcommittees for records, tissues, formulary, and infection control. The trustees have always approved the actions of the Medical Executive Committee, and through the years the principal controversies have been concerned with such matters as appointments and retirement age.

In 1956—ten years after the formation of the visiting staff—we opened a 300-bed modern Medical and Surgical Building, which has won professional and public acclaim. For some years we have had a surgical residency program, and the students tell us it is one of the most sought-after opportunities in Boston. We look forward to the time when we may establish a medical residency program too.

Our annual educational conference is a program of some significance in view of the current trend toward the psychiatric education of general practitioners. It is held under the joint auspices of the hospital, the Massachusetts Academy of General Practice, the State Medical Society, and the local APA District Branch. Large numbers of family doctors attend each year, and, through our relationship with the state AGP, we have formed a General Practice Section at the hospital. The Mental Health Liaison Committee of the AGP met with us to work out the details. We created staff appointments as "Attending Physicians, General Practice Section," and assigned various duties to these doctors. Some serve in a hospital unit or building dispensary where sick and injured patients are brought for treatment. Others work on the geriatric or medical services, either seeing selected patients by referral, or making rounds in a designated area for which they are solely responsible. In exchange for this regularly contributed service, the attending physicians receive instruction in psychiatric management from the senior psychiatrist on their service, and may attend seminars to which they bring case problems from their own practice.

Despite the academy's interest and enthusiasm, we have had difficulty in recruiting enough general practitioners. Few of these busy men can afford the regular investment of time; every moment of the family doctor's working day is filled with patients who need his service, and he is understandably reluctant to sacrifice the patient-service and income he would have to forego to come to the hospital weekly or even once every two weeks.

Functions of Attending Psychiatrists

We employ part-time private psychiatrists to assist us in all three phases of our program—service, training, and research. These psychiatrists make the annual mental examinations, and help in our aftercare program, especially in the "control clinic" which meets each week. Patients who are on trial-visit come to this clinic, or patients with a full discharge may report to it for brief evaluation, renewal of drug prescriptions, and assessment of drug effectiveness. Those who need more prolonged therapy are assigned to individual members of the attending staff, who work on a fee-for-service basis. These attending psychiatrists help to supervise our psychiatric residents, lead one of our twice-weekly seminars for residents, teach at a weekly case conference, or lead a seminar open to all staff members.

The "Board of Dreamers," a planning group which meets regularly, consists of distinguished attending psychiatric consultants, senior psychiatrists in charge of our services, and the senior research project directors. This board discusses the general problems of the research program, how it might better be organized, and what new research projects should be undertaken. An advisory group, made up entirely of psychiatrists in the community who contribute advice and assistance, is attached to each individual research project.

Appointments of psychiatrists to the Courtesy Staff are approved by the Medical Executive Committee and limited to graduates of our own residency program who are practicing locally. This arrangement maintains a harmonious therapeutic program throughout the hospital. Patients who pay for care may have their private psychiatrist attend them during their hospitalization, and they or their families make financial arrangements directly with the attending psychiatrists, not through the hospital. If a patient's funds are limited, however, the state has first claim. Naturally, all attending staff members may follow their patients who are admitted to the hospital.

Unsolved Problems

There are nearly always more patients in the hospital who need individual psychotherapy than there are therapists to meet the demand. When the patient or his relatives have sufficient money, we make an effort to find a therapist on either our regular or courtesy staff who will accept the patient. We can usually find somebody if the patient is on open-ward privileges and can travel to the doctor's private office, but few psychiatrists can spare the time to visit the hospital regularly to see a patient.

From a small beginning with 30 attending physicians and an annual budget for $30,000 for consultant service, the 12-year-old program now includes 70 visiting men at an annual cost of $100,000. Even now, this budget is unrealistic, because the salary schedule has not been revised since 1949. We still pay only $2 for mental and physical examinations. If a physician sees one patient for treatment, he may charge $10; if he sees two, $20; but three or more are classified as a clinical session for which he is paid $25. We follow the Blue Shield schedule, but we may not charge more than $60 for any surgical procedure regardless of its complexity.

There are other problems related to finance—for instance, the collection of fees for private care. Many patients today have some money available for medical expenses. Some have insurance benefits; others are entitled to disability or veterans' pensions. If the patient is indigent, the state will pay the bill of the attending physician from specially appropriated funds. But if the patient has an income, he must pay what he can for services. We urgently need a competent trust officer to search out resources, but so far have not been able to get such a position authorized on our payroll.

Occasionally, our Medical Executive Committee has had to discipline members of the attending staff for not keeping to their agreed schedules. If the committee finds that the individual has become too busy to invest enough time in the hospital's problems, they invite him to discuss the matter and to drop out if he feels he cannot contribute the needed service. Occasionally, the committee has had to resist pressure for special staff appointments. Its continuing objective is to get the best-qualified man who can work in harmony with the chief of the service.

With a visiting staff of over 70 part-time people, there is considerable pressure for better laboratory services. In spite of improvement through the years, the personnel and equipment have not kept pace with the legitimate demands. The State Society of Pathologists is making a survey for us, and will recommend methods of obtaining greater efficiency in laboratory procedures.

Communications, as in all such programs, are a continuing problem. We strive to maintain accurate transmittal of vital information between resident staff, attending staff, administration, laboratories and other services, but occasional misunderstandings are inevitable.

Our visiting staff, consisting of both psychiatrists and other medical specialists, has done a great deal to improve our over-all treatment program. Moreover, it has enabled us to set up residency training programs in surgery and psychiatry, as well as seminars and teaching conferences in various aspects of medicine. Other hospitals and agencies particularly appreciate these seminars and participate whenever a topic of special interest to their program is scheduled. The formal and informal participation of the various visiting staff members also has greatly improved the quantity and quality of research activities.

Other specific happenings indicate a successful operation: the adoption of our drug formulary by the state of Massachusetts; the drastic and progressive revisions made in our medical records; the procurement of new much-needed equipment through the insistence of the Medical Executive Committee; better dietary and food service, especially in the medical and surgical and geriatric sections.

Perhaps a major achievement has been the improvement of the public attitudes toward the hospital. Many of the visiting staff members are already well known in the city, and their professional reputations have been of great value to us. Citizens now realize that competent physicians, in all specialties, are looking after the patients in Boston State Hospital. ●

Discussion by Group

Of the 25 public hospitals represented in this discussion group, about a dozen had what they designated as "closed-open programs," meaning that they have an organized attending staff. Mid-city hospitals, such as Boston State Hospital, reported the greatest success with such plans, but one public hospital, further removed from a large population center, successfully uses young physicians just establishing themselves in general practice. At first this hospital used general practitioners on the geriatric wards for 10 or 20 hours a week. These doctors made rounds, helped in the follow-up of discharged patients and in the handling of mental defectives. They became able to screen other patients, keep psychiatric records, and make useful referrals for definitive psychiatric evaluation. Their skills increased with experience and they proved their value. A few, some with as much as 10 or 15 years of general practice, went into psychiatric training.

One participant said that since most psychiatric residents want to give all their time to psychotherapy, the utilization of attending physicians for rounds, medical examinations, and the like fills a definite and pressing need. The goal of all attending-staff programs is to assist a small full-time staff to give adequate treatment, but the hospital should set up clear stipulations about control.

How much responsibility can a nonpsychiatrist take? Legally, of course, the ultimate responsibility for care and treatment rests with the Board of Managers, and, as their representative, the physician-in-chief, or medical administrator. Because of this, some thought that part-time doctors, rather than attending physicians, afford better control and safety.

Should a private psychiatrist be allowed to give private treatment to a patient in a state hospital, to use the hospital's offices for such work, and under what conditions might this be permissible? There is a long-established precedent for such private treatment, which has long existed in many university medical school hospitals. Seven of the public hospitals represented allow their attending physicians to give private attention to hospital patients under definite conditions. Of the 46 people who took part in the discussion, 44 favored the utilization of selected private practitioners (psychiatrists or nonpsychiatrists) in public mental hospitals. Two opposed the plan.

The group devoted the last part of its discussion period to the subject of allowing full-time mental hospital psychiatrists the right to treat private psychiatric patients during their off-duty hours. This is not a new procedure, although it has not been used as widely or as openly as it might be.

Many of the more active and better-staffed state hospitals have been allowing this right for some time and, as a result, have been able to build and maintain outstanding psychiatric staffs. A show of hands indicated that 16 states represented in the group followed this practice. Most state laws have no restrictions to prevent it. While physicians occasionally take advantage by allowing their private practice to interfere with their regularly assigned duties, this is the exception rather than the rule and can be handled without difficulty.

Psychiatrists usually have a more optimistic outlook about their psychotic hospital patients when they are allowed to treat other types of mental illness in different settings. They show more job satisfaction and less inclination to change jobs. A psychiatrist who is well established in his full-time position and has a comfortable private practice, is less likely to move or to leave his state hospital job. Even if he leaves the state hospital to practice full-time, he is still saving taxpayers' money because he treats patients who, without such help, would eventually become state or federal charges. Finally, hospitals allowing this privilege are able to retain their best graduating residents and to procure the services of younger psychiatrists, because the income prospects are attractive. The consensus was that this is one of the best and most economical ways for state hospitals to obtain and keep highly skilled, highly qualified psychiatrists.

Arthur L. Peterson, M.D.
Recorder

EXPERIENCES IN A PSYCHIATRIC UNIT OF A LARGE GENERAL HOSPITAL

PRESENTATION BY THE DIRECTOR OF PSYCHIATRY

HARVEY J. TOMPKINS, M.D.
Reiss Mental Health Pavilion
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FOR THE PAST FIVE YEARS we have been developing a psychiatric division at St. Vincent's Hospital, an affiliate of the New York University Medical School. Our staff includes full- and part-time psychiatrists as well as attending psychiatrists in private practice. The latter give free time to the hospital for the privilege of being able to treat their patients in the psychiatric division and otherwise participate in its program.

A psychiatric service in a general hospital depends upon the interest and participation of the entire hospital staff. Similarly, the service's physical setting can aid or serve as an impediment. A psychiatric service in another building, regardless of how accessible it is to the rest of the hospital creates a barrier to developing the "openness" of the service. Since our unit is housed in a separate building, we have discovered these things by experience.

There is a direct relation between the degree of identification of the attending and visiting staff psychiatrists and nonpsychiatrists and the intimacy of the service, physically, with the rest of the hospital. Psychiatrists expect to enjoy direct relationships with the staffs of other specialties and disciplines and to have similar rights and privileges, including the opportunity to treat their own hospitalized patients.

Organizationally, the psychiatric service must have equal status with the other major hospital services in order to facilitate policies which propitiate good relationships and foster its own development. Some policies and procedures will be similar to those of other services; some, of necessity, must depart from the historical philosophies and methods of the general hospital.

It is in the area of criteria for admission to the intramural service that difficulties in interpretation may occur. Despite psychiatry's advances, including the increasing effectiveness of short-term therapy, a great deal of psychiatric illness is chronic. It is impractical, if not impossible, for a psychiatric service in a community hospital to provide long-term treatment. Therefore, the service must establish rules for admission eligibility (including transfer from other hospital services) and impose limits on the length of treatment time; our limit at St. Vincent's is approximately 90 days. However, we are responsible for assisting colleagues to secure longer term care for their patients through use of affiliated facilities or community resources.

Judicial Admissions Accepted

Medicolegal implications must also be considered in admitting patients. Initially, we limited our acceptance of patients to those who came voluntarily. However, to better serve the hospital and the community, we secured state licensure to receive and retain involuntary patients, including those committed to us by judicial procedure. While a minimum of patients—less than 5 per cent—are on involuntary status at St. Vincent's, we are careful to observe state laws and to maintain proper state records.

The discharge of both medical and legal responsibilities is shared by the division director and the referring physicians. This shared responsibility is standard in all divisions of the hospital. However, the director of psychiatry, because of his unique responsibilities, participates in the admission and hospital stay of a patient in a more immediate sense than do the directors of other divisions. In keeping with the current trend, all physicians with staff appointments at St. Vincent's including directors of divisions are required to carry between $100,000 to $300,000 of liability insurance.

While the development of his private patient's therapeutic regimen is the immediate responsibility of the attending psychiatrist, he must conform to the over-all division program, particularly as it applies to the paramedical services. The attending psychiatrist can best acquaint himself with the program by participating in ward and division conferences, including those dealing principally with administrative matters.

Private and Indigent Patients Treated Alike

When the attending psychiatrist has complete knowledge of nursing routines, it is easier for him to care for his patient and to inform both the patient and his family about ward policies. For instance, our attending psychiatrists know that therapeutic indications and not personal preference will determine the type of room in which we place a patient; also, that we do not separate the private or paying patients from those who are indigent; and that all jointly engage in similar ward activities. This poses a problem at times in handling VIP's. Understandably, their attending psychiatrists under pressure from others (usually the families) will ask for transfer to a single- or double-bedded room, but will have little or no therapeutic substantiation for their requests. This problem can become even more difficult when the patient realizes that the hospital charge is the same regardless of which room he occupies.

No good rule is totally inflexible and an exception is sometimes helpful to the family—and to the doctor. Nevertheless, preferential attention can disturb the ward staff who see it as an abridgment of the unified therapeutic program, a threat to proper staff attitudes, and, seemingly, as an invasion of the rights of all patients.

The division's policy encourages private psychiatrists, with attending status, to treat patients in the hospital. However, we will accept patients referred by our attending psychiatrists for placement under the care of full- or part-time staff. The patient, after discharge, returns to the referring psychiatrist. When more attending psychiatrists accept responsibility for their hospitalized patients, the patients will receive better continuity of care and there will be less need for salaried staff psychiatrists. In common with larger teaching hospitals, we believe that there should be a core of full- or part-time staff personnel; more assistance of attending psychiatrists would release this personnel for more specific clinical, administrative, teaching, and research tasks. The director of a service, at least, should be full-time, and a satisfactorily functioning outpatient department also requires at least one full-time psychiatrist, as well as a full-time psychologist and social workers.

At St. Vincent's the private psychiatrist, accepting hospital responsibility for his patient, is supported by the available services of a resident, social worker, and, if necessary, a clinical psychologist. The attending psychiatrist determines the extent of these services and the degree of participation of the nursing staff in the treatment of his patient. He prescribes occupational therapy and recreational activities, and consults with the director when he has any unusual request to make.

As a teaching hospital, we are anxious for our residents and trainees to be engaged in a training situation at all times. Since approximately half of the patient-population is indigent, and, ordinarily, private patients cooperate in our training and research efforts, a sufficient amount of clinical material is always available. Our psychiatric service can care for a large number of indigent patients without critically increasing our financial deficit, because their hospitalization costs are in part shared by the city and state under the New York State Community Mental Health Services Act. The city assumes similar responsibility for indigent medical and surgical patients.

Expanded coverage for mental illness offered by Blue Cross, Blue Shield and other major medical plans are making it economically possible for hospitalized patients to be treated by private practitioners.[1] One can anticipate that the policyholder of the future will expect his private psychiatrist to attend him in the hospital just as medical and surgical patients are treated by their physicians.

Responsibility to Hospital and Community

Our psychiatric division has a dual responsibility to the hospital and to the community. Attending physicians of other hospital services consult with attending psychiatrists when private patients are involved; consultations involving indigent patients are performed by residents under the supervision of attending psychiatrists. If a patient in another service of the hospital—the surgical ward, for instance—requires psychiatric treatment, he receives it if at all practical on the surgical ward with the assistance of the referring physician who consults with the psychiatrist.

It is not surprising to find that physicians in other divisions are increasingly able to give psychiatric support to their patients and are more selective in their requests for consultations. After the consulting psychiatrist evaluates the case, the referring physician may direct the major therapeutic effort under the psychiatrist's supervision. When the patient's specific therapeutic needs require residence on the psychiatric division, the psychiatrist assumes the principal but not exclusive responsibility for the patient. After specialized psychiatric treatment is completed in the division, the patient is returned to the referring physician for indicated care, including psychiatric support if it is within the physician's competence. These relationships are enhanced by the ease with which other specialists work with us in caring for physical illness and promoting teaching and research.

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[1] *Fact Sheet No. 15, Joint Information Service of the APA and the National Association for Mental Health.*

The concept of continuing involvement of the nonpsychiatrist physician with his hospitalized patient is increasingly evident in referrals from the community. Originally, all requests for hospitalization of private patients from physicians other than psychiatrists were referred to a psychiatrist for evaluation before we considered admission. From time to time, private psychiatrists were not available immediately, and the patient was evaluated on admission by or under the supervision of salaried staff. Gradually, the evaluations of nonpsychiatrists became acceptable.

With the development of greater professional intimacy, we consult our medical colleagues about developing a patient's therapeutic regimen and advise them of the patient's progress during his hospitalization. We encourage them to personally observe their hospitalized patients. We have not given actual responsibility to a nonpsychiatrist for the treatment of a patient who is in the psychiatric division; however, we consider many physicians to be capable of providing psychiatric care for their patients after hospitalization.

We have developed procedures to facilitate consultation with nonpsychiatrists who, through their contact with the hospital, have become more aware of the local psychiatric resources available to them. This is a significant educational venture, and we are heartened by the increasing competence of our colleagues and the benefits derived by our staff from its exposure to broad medical relationships.

With the increase in our attending staff and in the ability of our nonpsychiatrist colleagues to care for less pronounced conditions outside the hospital, our requests for admission currently include more patients afflicted with serious, complicated, and refractive types of psychiatric illnesses. With a more experienced staff we are now able to successfully treat the more seriously disturbed and have revised our concepts of chronicity, particularly in the field of geriatrics. The older patient, in an acute phase of disability, can be hospitalized more readily and, in many instances, helped sufficiently to return home. This is done with a minimum of interruption in his relationships with his family and his physician, both of whom remain involved during the patient's hospitalization. Despite this change in the character of our patient-population, we transfer a yearly average of from 7 to 8 per cent of our patients to other institutions for longer term care.

However, the average length of stay has increased from several weeks—when most patients were depressives—to about eight weeks with the presence of a larger number of schizophrenics (many with a history of previous hospitalizations) and patients with various character disorders in different phases of decompensation. Our expanding training programs and the follow-up facilities in the hospital and community that can handle our large component of indigent patients have added to our ability to broaden the types of patients we accept.

Professionals other than psychiatrists also participate in the work of our low-cost general purpose outpatient psychiatric department. We place emphasis on careful screening and intensive psychotherapy for appropriate patients. Currently, this department's major efforts are given to consultation, education, and short-term therapy usually requiring less than 10 visits. The clinic staff evaluates referrals from social agencies and similar sources with the help of agency representatives. They evolve a therapeutic regimen, which, in an increasing number of instances, can be carried out by the referring group. The outpatient department also operates the posthospital follow-up clinic for our indigent patients.

The ongoing policies of allowing private-practice psychiatrists on attending status to treat their patients in the hospital and of involving nonpsychiatrist physicians in the daily activities of the psychiatric service in this large general hospital have, we believe, improved our psychiatric missions of service, consultation, and education. •

Discussion by Group

THE MAIN ISSUES during this discussion were whether the staff of a general hospital should include psychiatrists in private practice in the community, whether general practitioners should be permitted to admit and follow psychiatrically ill patients, and medicolegal considerations.

There was general agreement that private psychiatrists should be included on the staff, but that the professional supervision of these physicians will vary according to the practice followed in the other hospital services. The character and practices of the psychiatric service should follow as closely as possible those of the entire hospital. If, for instance, a particular general hospital is engaged primarily in the treatment of acute illnesses, then acutely ill patients will also predominate on the psychiatric service.

It was agreed that, in return for the privilege of admitting and following patients, attending psychiatrists should be given definitive hospital assignments on the basis of interest and need. These may be in the outpatient clinic, in the research section, in teaching, or on one or more of the other services.

There was less agreement as to the role of the general practitioner on the psychiatric service. Should he have any therapeutic responsibility once his patient is admitted, and, indeed, does he want to assume any? Despite the many psychiatric courses now being given for the general practitioner, the consensus was that he should not give psychiatric treatment to any of the hospital patients. His presence, however, can be helpful to his psychiatric patient, in that he is a friend, and can support both patient and family during the treatment period. It would be entirely proper for him to continue treating his patient's physical ailments.

Many expressed concern that the general practitioner might evolve into an inadequately trained junior psychiatrist. The purpose of educational courses or exposure to a psychiatric service should be only to round out his training, enhance his ability to handle his patients, complement his other special skills, and enable him to recognize emotional problems in his patients.

There was some lively discussion about the value—legal, psychological, or therapeutic—of the psychiatric patient's signing a special admission paper. In most communities, such a paper serves no legal purpose, and, if the stigma of psychiatric hospitalization is to be removed, the patient must be admitted to the psychiatric service in precisely the same manner he would be if he were going to the medical or surgical service.

One physician believed that a signed paper could be useful in the early stages of hospitalization when the patient had some ambivalence about accepting treatment, but few people agreed. "Reluctant patients," said one participant, "should either be released on demand, or told that if they refuse to stay in the general hospital, they will be transferred to a state hospital." Members of the group thought this should be known as "legal paraldehyde"!

William A. Harvey, M.D.
Recorder

THE NONPSYCHIATRIST PHYSICIAN IN PSYCHIATRIC HOSPITALS OR SERVICES

REACTIONS OF U. S. PSYCHIATRISTS

WILLIAM E. SHEELEY, M.D., *Chief*
APA General Practitioner
Education Project

A CONSIDERABLE NUMBER OF NONPSYCHIATRISTS, on their own initiative, are answering the expanding public demand for psychiatric care. This unsolicited aid troubles some psychiatrists who forget that their own campaign to remove the stigma from mental illness apparently has been effective: it is a major reason for the expanding demand for psychiatric care.

Psychiatrists have fostered greater public acceptance of mental illness as a medical condition. They also have promoted interest in obtaining necessary psychiatric care by pushing for more active therapy and early discharge from state hospitals as well as for preference for care in the community. They favor sheltered workshops and halfway houses, community mental health clinics, and psychiatric services in community general hospitals.

However, there are relatively few psychiatrists, especially in small towns and rural areas, and these few tend to enter private practice. By doing so, they reduce the patient-to-psychiatrist ratios in community mental health clinics, community social agencies, and general hospital psychiatric wards. Therefore, it is not surprising that people with psychiatric problems are turning to nonpsychiatrists, such as clergymen, social workers, psychologists, family physicians, and counselors of various kinds.

A number of nonpsychiatrist physicians—especially recent graduates of medical schools—are doing a reasonably good job of handling their patients' psychiatric problems. Nevertheless, many psychiatrists wish that these physicians would refer cases more often and more astutely and would rely less on tranquilizers and exhortative, paternalistic psychotherapy. Psychiatrists hope that the increasing demands for care can be met more effectively than they are at present. They have proposed a variety of solutions. One proposal is to give the family physician a more responsible and active therapeutic role in the community general hospital psychiatric service.

It seemed logical for us in the American Psychiatric Association General Practitioner Education Project[1] to sample psychiatrists' reactions to this proposal. Accordingly, we sent approximately 175 inquiries to heads of medical school departments of psychiatry, chairmen of liaison committees of APA District Branches, and directors or commissioners of state mental health programs. We asked them to give us their opinions of the proposal and to tell us about their experiences with it.

This survey elicited 68 replies; 46 per cent of the respondents opposed the idea, 26 per cent favored it, and 18 per cent favored it with certain reservations and stipulations. The remaining 10 per cent had no opinion.

Negative Points of View

Those opposing the idea seriously question the nonpsychiatrist physician's competence to give effective inpatient psychiatric therapy. They suggest that physicians, perhaps because of their own personality problems or for other reasons, create too many difficulties in the hospital situation. Many physicians, they say, either are not sensitive enough to the psychiatric implications of treatment or have rigid and predetermined ideas about it which in fact may be anti-therapeutic. A liaison committee chairman points out that "the general practitioner or internist has not hesitated to admit patients to his own care to treat them as he sees fit, and to ask for consultation only when he sees the need. . . ."

A professor warns that interpersonal difficulties between physician and hospital staff may arise because often it is difficult for untrained people to fit into a psychiatric hospital. A state commissioner expands this point, recounting instances when physicians have countermanded psychiatrists' orders, become too involved in patients' problems, and actually have taken patients out of the hospital —in the physicians' own automobiles. He goes on to say that inept physicians may be as sick as the patients and "are the ones most likely to take advantage of staff privileges."

Survey replies reveal a fear that encouraging the nonpsychiatrist physician to treat patients in a psychiatric unit would affect the quality of all psychiatric therapy. One commentator opposes letting general practitioners or other medical specialists give dynamic psychotherapy or drug therapy because of the "horrible examples" he has seen of their attempts. Another thinks that if a mental patient is "sick enough to be admitted to a hospital . . . he should be treated by a psychiatrist. . . ."

Some psychiatrists urge the establishment of criteria to prevent the general physician from contributing to the deterioration of psychiatric care. "Encouraging the general practitioner to consider himself an adequate psychiatrist," one says, "would result in ineffectual treatment which would only lead to patients leaving physicians' care and seeking out ministers, psychologists, chiropractors, and other inadequately trained personnel on the fringe of the healing arts."

Cases are reported of psychiatric patients being hospitalized by general practitioners or internists for a week or two before the physicians request consultation. At other times, the physicians discharge patients prematurely only to find that further hospitalization is required. In the meantime, the process has cost the patients a great deal in loss of work, time, and money.

A professor believes that the nonpsychiatrist is too busy to offer adequate care to a hospitalized mental patient: "Just how he could discharge his obligation while coming in to see the patient one or two times a week for a few minutes every day is beyond me."

No Need for Nonpsychiatrists?

Many of the respondents see no need for the nonpsychiatrist to assist with inpatient treatment. They believe that psychiatrists are numerically equal to the demand for them and that encouraging nonpsychiatrists to undertake inpatient therapy would open a Pandora's box. One suggests that "it might create problems that are present in some communities in reference to surgery." And there is a commissioner who succinctly sums up the matter: ". . .there is a fairly healthy distrust on the part of psychiatrists in the generalists."

Some of the psychiatrists do not consider short postgraduate courses to be adequate means of imparting important aspects of their specialty to general practitioners. The chairman of such a course says: "From my experience in teaching the

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[1] *Established in 1957 to improve the psychiatric understanding and skills of family physicians.*

nonpsychiatrist physician, I think it unwise to permit family physicians to hospitalize and treat psychiatric patients." He believes that the welfare of the patient demands the best technical assistance in times of stress.

Positive Points of View

Those surveyed who favor extending hospital privileges to nonpsychiatrist physicians support their stands with opinions of their own. They emphasize that it is unlikely that there will be enough psychiatrists to carry the entire work load and point out that much psychiatric therapy is being done now by persons who are not even physicians. They believe it is paradoxical that the psychiatrist often seems to prefer to have a lay person give psychotherapy than to have a medical colleague do so.

Evaluating the people who need psychiatric treatment, one commissioner believes that many do not require all of the skills of a fully trained psychiatrist. He estimates that "up to 85 per cent of psychiatric patients can be handled by the family physician." In any case, adds a lay hospital administrator, "Some treatment is better than no treatment. We have had good results in a few minor cases."

One professor points to nonpsychiatrist physicians as a "big source of potential manpower," especially in many outlying communities. Another comments, "If all the emotional disorders are to be adequately treated, we will have to look more and more to the medical profession for active help, with the psychiatrist (in) the role of consultant or supervisor. . . ."

One psychiatrist thinks that the family physician has something unique to offer many mental patients that would be valuable even if the supply of psychiatrists were adequate—the confidence an able and sympathetic doctor inspires in his patients and the rapport he establishes with them. In treating uncomplicated neuropsychiatric problems, these abstract assets can be as important therapeutically as the physician's specialized training.

Other psychiatrists emphasize that, in any case, nonpsychiatrist physicians are giving psychiatric therapy. They note that some physicians admit obviously and often exclusively psychiatrically ill patients to their own services. A commissioner reports that he has not found all such physicians unwilling to accept advice from psychiatrists. He believes that this willingness is enhanced when physicians have had postgraduate courses in psychiatry.

Several of the psychiatrists participating in the survey uphold the idea of training the physician and then guiding him in psychiatric therapy. One says, "I think we might help to (1) encourage this, (2) help the physician learn about our specialty, (3) protect him from being overburdened." Another believes that "with appropriate consultations a selected physician with adequate training would function quite well." And a commissioner reminds us that, after the psychiatrist, the family physician is best qualified to assist in providing good mental health care. The possibility is suggested that trained family physicians could even undertake the supervision of members of other clinical disciplines allied to psychiatry.

Those who favor opening the doors of psychiatric units to general practitioners challenge the idea that hospitalized mental patients need greater therapeutic skills than do those in clinics and other ambulatory situations. One flatly states that "to say . . . cases . . . severe enough to require hospitalization *ipso facto* require the care of a specialist is to ignore the true facts."

Several psychiatrists suggest that permitting physicians to treat patients in psychiatric units would enable psychiatrists to exercise a measure of supervision over any substandard treatment and, concurrently, to teach the physician better psychiatric skills. A professor supports this viewpoint: "The nonpsychiatrist physician already cares for the bulk of psychiatric disorders, many of them in general hospitals. In addition, we assign patient responsibilities to first-year residents who have very little experience in the care of sick people. It would be hoped that postgraduate courses and supervision could be available. . . ."

According to one commissioner, the physician would do a better job treating psychiatric illness on a psychiatric service than elsewhere because he would have the assistance of a nursing staff sophisticated in handling psychiatric problems.

Many respondents see no reason why nonpsychiatrist physicians could not be controlled adequately by regulations established by the psychiatrist-in-chief and supervised by him and other members of the psychiatric staff. Others say that the relative competence of the physician would be an important consideration in opening the doors of psychiatric units to him. The psychiatric staff should determine this competence and establish the degree of responsibility each physician would be allowed to assume.

Need for Further Evaluation

These, then, are some of the pro and con comments on utilizing the nonpsychiatrist physician in general hospital psychiatric service treatment. They indicate that it would be worthwhile for psychiatrists to consider this proposition further. Perhaps, basically, it is an unsound and unworkable idea, or, perhaps, it offers a way to tap a reservoir of potential aid for the mentally ill who often receive inadequate treatment today. •

COMMENTS OF AMERICAN ACADEMY OF GENERAL PRACTICE

B. WHEELER JENKINS, M.D.
Regional Chairman,
Committee on Mental Health
AAGP

In the history of medicine, new ideas always have met some opposition. This is as it should be. If they were accepted immediately and got off the ground too easily they might, like some experimental airplanes, come crashing down and do much harm.

The policy of opening psychiatric hospital wards to the nonpsychiatric physician is a new idea. The pioneers who are advancing it must defend themselves against criticism, much of which is sound and worthy of consideration. Many of us in the Academy of General Practice believe that our members would be better family doctors if they would expend as much energy treating the emotional aspects of a patient's illness as they do the organic ones. But those of us who are implementing this idea are well aware of the difficulties we face. For one thing, we realize that not all general practitioners are capable of handling their patients' minor emotional problems, just as all surgeons cannot handle every surgical problem that confronts them.

AAGP Requirements

However, no organization is more careful in qualifying its members than is the Academy of General Practice. Doctors remain in our academy only if they satisfy certain postgraduate requirements on a year-to-year basis, thereby building up what we call "category credits." Every year each member must submit documentary evidence of Category I credit, which is allowed only for courses taught by the faculty of accredited medical schools or similarly sponsored programs. If the member does not present evidence of 50 hours of Category I credit every three years along with 50 hours of Category II credit obtained by attending scientific meetings, he is dropped automatically.

Some psychiatrists say that a little psychiatry is a dangerous thing, but those of us in general practice who have become even slightly familiar with this specialty have found it to be refreshing, stimulating, and quite helpful in making us better doctors. Many of us have taken postgraduate courses that have made us more aware of the power within us, and also of our limitations. It has not been necessary for us to become deeply absorbed in psychiatry to solve some of the lesser emotional problems of our patients. We know what we *can* do; likewise, we know what we *cannot* do. The necessity to recognize limitations is not a unique criterion for those who deal with the emotional aspects of medicine; it applies equally to any branch of the healing arts.

With these basic facts established, what are some of the other pertinent pros and cons regarding the admission of general physicians to practice in mental hospitals?

Advantages to the Patient

First, let us consider the patient. Referral to a mental hospital would be easier if the family physician could assure a patient that he would see him frequently during hospitalization and assist with his treatment. This assurance would help to remove the sense of abandonment a patient experiences if he does not know when he will see his doctor again, and would make him feel better about entering the strange confines of a psychiatric hospital.

The open-staff policy also would benefit the patient during aftercare. So many times he is admitted to the psychiatric hospital, treated and discharged, and fails to return to his family physician —not through any fault of his own—but simply because he was not told to do so by the person discharging him. This should not be and certainly does not happen very often when patients are referred to other specialists. If the referring physician were a part of the hospital's therapeutic team, he obviously would be better qualified to conduct the aftercare.

Kurland and Nilsson[1] found that half of the patients who had been referred to and discharged from a Maryland state hospital failed to report to the agency to which they had been referred for aftercare—the outpatient department, the private psychiatrist, or the family physician. Interestingly enough, not all patients who were referred to their family physicians reported to them, but, of those referred to the psychiatric clinic, more than half went instead—on their own volition—to their family physicians. More of these discharged patients referred themselves to their family physicians than to any other agency. This shows that there is still a wide breach between psychiatry and general practice.

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[1] *Kurland, A. A., and Nilsson, G. L.: The General Practicing Physician and the State Psychiatric Hospital, Maryland Med. J. 10:134-38, Mar. 1961.*

Advantages to the Hospital

It would be of inestimable value to the hospital itself to allow many of the patients who are attending the clinics to be seen by physicians who are equipped to handle their emotional problems. These doctors may not be board-rated psychiatrists, but then neither are the residents-in-training. It is a well known fact that many nonmedical personnel—psychologists, nurses, and some social workers are doing much of this type of therapy right now. Wouldn't it be better if it were being done by doctors who worked under the psychiatrist's supervision and could consult with him when the situation called for it? This approach would allow the psychiatrist to devote more of his time to deeply disturbed psychotic patients.

There are psychiatrists who believe that the doctor might do more harm than good in handling these cases. For example, the doctor might hold on to them too long. He might not recognize a serious psychotic state. He might, by mishandling the case, make subsequent therapy more difficult. We realize that this could happen if an unqualified doctor were allowed to work in the psychiatric hospital. (It could happen in the doctor's own office, too.) This is a problem for psychiatrists; they will have to decide at the outset whether or not the general practitioners admitted to their hospitals are qualified.

The problem of qualification exists in every branch of medicine. All specialties observe and estimate the professional qualifications of those applying for work in their fields. Surely, these policies could be applied to the problem at hand. It is up to the psychiatrists in mental hospitals to become interested in the operation of postgraduate courses for nonpsychiatrists, to staff these courses, and to determine qualifications for admittance to the staff.

On the other hand, some patients' disturbing problems are so intimate that they would rather not discuss them with the family doctor. If patients of this type realized the doctor was coming into the hospital to participate in their therapy, they might be more difficult to handle. In such cases, the family doctor should offer only general support and do no interviewing. But the patients might welcome a familiar face in strange surroundings, and, perhaps, a continuing doctor-patient relationship could improve the rapport between the two.

Back to Hippocrates

Much has been written in recent times about the general practitioner treating the whole human being. "To treat the man well, the physician must examine him as a whole, not merely as an organ, or a body part in which the disorder seems to be located. The doctor should enquire into the background of the individual's life, his antecedents, his temperament, his occupation, his habits, his pursuits, his regimen, his conversations, his manners, taceturny, his thoughts, his sleep, or the absence of sleep, and sometimes even into his dreams, what they are and when they occur, his picking and scratching, his tears. From these as well as from his symptoms we must form our judgement." These are the words of Hippocrates. They were written over 2,500 years ago and are just as true now as they were then. •

MEDICOLEGAL ASPECTS OF OPEN STAFF PROGRAMS IN PSYCHIATRIC SETTINGS

GEORGE E. HALL, *Director*
Medicolegal Department
American Medical Association

LAWS THAT SPELL OUT THE MEANS AND METHODS of caring for mentally ill patients vary in each state. They also vary in different types of hospitals. Staff psychiatrists and superintendents in state mental hospitals face one kind of medicolegal problems; those in general hospitals that have psychiatric services face another kind. There are differences in standards of care, methods of handling patients, and the degree of protection that the physician and the hospital must exercise on the patient's behalf. Four of the chief differences are those relating to the patient's admission, the patient's discharge, the medicolegal liability of the attending psychiatrist, and the medicolegal liability of the hospital.

- *Patient's admission*: This discussion will not include admissions by court orders or by emergency provisions of a mental health act, applicable when the patient is in danger of causing injury to himself or others. Such patients usually are sent to state or private mental hospitals which are licensed or approved by appropriate state agencies.

The general hospital is concerned primarily with patients who voluntarily submit to hospitalization for mental care. However, many mental health acts that define and provide for the admission of a voluntary patient to a mental hospital are based on the assumption that the patient instigated his hospitalization himself or had a relative or attorney do it for him. If someone else filed his application, a patient can hardly be described as "voluntary"; his more likely classification is that of a nonprotesting patient.

Some states require a voluntary patient to be mentally competent to make the application, but 30 states permit either the patient or his guardian to apply. Many jurisdictions may question whether or not this type of voluntary admission can be accepted by general hospitals, unless the hospitals have been approved by the appropriate state agency.

- *Patient's release*: The nature of a patient's admission is a very important factor in his release. When the admission results from a commitment proceeding or other type of involuntary admission, the hospital is not obliged to release the patient merely at his request. This is also true of the typical unprotested admission. In such a case, the hospital superintendent may hold the patient until he is satisfied that treatment is no longer necessary.

Interdependence of Admission and Release

When there has been true voluntary admission, the hospital is not justified in keeping the patient after he has asked for release. When the psychiatrist or the superintendent believes the best interests of the patient and his community will be served by his continued hospitalization, they can avoid releasing him only by commencing the necessary proceedings to have him committed or detained under the provisions of the mental health law. For example, if the voluntary patient, at the time of admission, were to agree to a discharge within ten days after his request for it, this would probably furnish sufficient time for the attending physicians to take any needed delaying action. Most general hospitals undoubtedly will not be too anxious to become involved in these procedures. If not, they should be as certain as it is possible to be that the patient is a truly voluntary one.

- *Physician's liability*: The basic liability of the attending physician and the staff or consulting psychiatrists in the general hospital, and the staff psychiatrist of the state or private mental hospital, is the same. Each must render to a mentally ill patient the standard of skill, care, and judgment exercised by other psychiatrists in the community. Inadequate facilities in the general hospital might make it more difficult for the psychiatrist in the general hospital to equal these standards. We do not know whether or not the courts will find it necessary or equitable to recognize two different standards—one for specialized mental institutions and another for psychiatric units in general hospitals. It is doubtful.

We must also remember that the solidarity of the physician's relationship with a mental patient is not as firm as with a surgical patient. This adds to the difficulty of handling mental patients in general hospitals. However, it is by no means impossible for a general hospital psychiatric unit to equal the efficiency of the mental hospital in caring for mental patients, but it requires more effort and vigilance on the part of the unit's staff.

Division of Responsibilities

There are two methods of handling the psychiatric patient in the general hospital: (1) the physician may continue to attend his patient in the psychiatric ward, consulting members of the psychiatric staff when necessary, just as he would consult a surgeon, internist, or other specialist if the needs of his patient required it; (2) the physician may arrange for the hospitalization of his patient and then refer him to the total care of a member of the psychiatric staff. In this case, the psychiatrist is solely responsible for the adequacy of the medical care furnished to the patient; the private physician is out of the picture.

Under the first method, the physician and the consulting psychiatrist would handle the patient jointly and be mutually responsible for damages caused by their negligence. Therefore, the therapeutic value of integrating the private physician into the patient's psychiatric care carries with it a responsibility the physician may not want to assume.

Another problem which can plague the physician who is trying to care for a mentally ill patient in a general hospital is that of consent for performing medical or surgical procedures that are necessary to properly treat the patient. Most if not all of the mental health acts contain a provision stating that a mental hospital superintendent shall have the right to consent, on the patient's behalf, to the performance of such medical and surgical care as might be necessary to improve the patient's mental or physical condition.

This is certainly not true in general hospitals where, for example, administrators have no authority to substitute their consent for surgery for that of the patient. Without the patient's consent, the surgeon would be guilty of assault and battery. The patient would have no trouble obtaining a judgment for damages since the courts are becoming stricter in holding that the patient must be fully informed of such procedures and what their ultimate results might be. Here again the nature of a patient's affliction is important. The more serious his condition is, the less likely the court will be to recognize the validity of a consent signed by him.

By practicing medicine, all physicians assume calculated risks. If the physician believes that the patient, because of his condition, possibly doesn't understand the meaning of the consent he has given, the physician also should obtain the consent of the patient's guardian.

- *Hospital's liability*: Usually, in state or private mental hospitals the employer is legally responsible for negligent acts perpetrated by employees—staff psychiatrists, nurses, orderlies, aides, and others. A mental hospital can act only through its agents, and will be liable for their acts through the doctrine of *respondeat superior.*

General Hospital Liabilities

A general hospital also acts only through its agents and servants. However, its physicians are independent contractors rather than employees. The hospital, therefore, is not responsible for the negligent acts physicians may perform while treating a patient. An exception to this might exist if a staff member were performing administrative functions on behalf of the hospital, and the patient suffered injuries because of the negligent performance of these functions. But this is not the usual source of injuries caused by negligence.

The general hospital *is* liable for negligent acts its nursing and other personnel might commit during the course and within the scope of their regular duties. This puts greater responsibility on the nursing staff of the psychiatric unit of the general hospital than upon the nursing staff in other divisions of the hospital. The reason for this is that the hospital owes to its patients protective care commensurate with the ability of the patient to protect himself.

In *Law of Hospital and Nurse,* Hayt, Hayt, Groeschel, and McMullan[1] state: "The voluntary general hospital must give the patient in its psychiatric unit the kind of treatment customarily afforded for the same illness by hospitals operating similar units in the locality. Although the hospital is not the insurer of the patient's safety it must guard him against untoward happenings that a reasonable person should anticipate under similar circumstances. It does not guarantee to prevent unpredictable conduct on the part of the patient. No inflexible yardstick exists to measure what constitutes ordinary care or the lack of it. In each case the question must be determined in the light of its own facts and circumstances. Ordinary care in the case of a mental patient must be commensurate with his known suicidal, homicidal, or other dangerous tendencies." The general hospital that maintains a psychiatric unit must appreciate this added responsibility and exercise the necessary degree of diligence in acquiring the nursing personnel who staff it.

No Insurmountable Barriers

These four matters discussed above are by no means the only ones that vitally affect the operation of a psychiatric unit in a general hospital There are many others—the release of the mental patient's record, the use of mechanical and other restraints, the added care that must be taken to protect the mental patient's civil rights, etc. Nonetheless, there is no reason to believe that there are any insurmountable legal barriers to the treatment of the mentally ill in psychiatric wards of general hospitals. •

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[1] *Hayt, Emanuel; Hayt, Lillian R.; Groeschel, August H.; McMullan, Dorothy: Law of Hospital and Nurse, Hospital Textbook Co., New York, N. Y., 1958, p. 283.*

Have You Read?

EARNINGS AND SUPPLEMENTARY BENEFITS IN HOSPITALS MID-1960 (15 areas)—Bulletin No. 1294, U. S. Department of Labor, May 1961. This publication summarizes survey findings of hospital employees' earnings and supplementary wage benefits in 15 major metropolitan areas. The survey covered private, state, and local government hospitals. A description of the pay system used by federal government hospitals is included. Available from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. 50¢.

THE TREATMENT OF CRIMINALS IN INSTITUTIONS—by A. M. Roosenburg, M.D., published in the July 1961 issue of the *Bulletin of the Menninger Clinic.* The Van der Hoeven Clinic in Utrecht, The Netherlands, is a penal institution which is also a modern treatment center. The clinic attempts to trace by psychotherapy the main experiences that have led to a patient's deviations, help him integrate the new insights that he gains through treatment, and create an atmosphere in which his healthy qualities are used.

HIGHLIGHTS OF PROGRESS IN MENTAL HEALTH RESEARCH (1960)—Public Health Service Publication No. 824, prepared by the Publications and Reports Section, National Institute of Mental Health. This report includes selected findings of research conducted during 1960 in NIMH laboratories and in nongovernment research centers that received support from the NIMH. The research categories discussed in the pamphlet are treatment, biological studies and psychopharmacology, childhood studies, aging, delinquency, suicide, retardation, drug addiction, and alcoholism. Available from: Superintendent of Documents, Government Printing Office, Washington 25, D. C. 25¢.

PSYCHIATRIC POINTS OF VIEW REGARDING LAW AND PROCEDURES GOVERNING MEDICAL TREATMENT OF THE MENTALLY ILL—This document contains the testimony presented to the U. S. Senate Subcommittee on Constitutional Rights on March 28, 1961, by Drs. Francis J. Braceland and Jack R. Ewalt on behalf of the American Psychiatric Association and the National Association for Mental Health. Copies are available without charge from the Publications Office, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington 9, D. C.

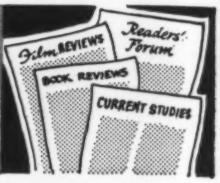
RECOGNIZING THE SCHIZOPHRENIC BEFORE HE IS PSYCHOTIC—Ainslie Meares, M.D., in the August 1961 issue of *Consultant.* Schizophrenia develops in persons with introvert personalities, the apparent exceptions being in those who exhibit a pseudoextroversion. Signs of either an increase or a decrease of introversion may be a warning that the young introvert is developing schizophrenia. Its onset is often preceded by changes in the individual's usual way of looking at things; anxiety is a very important sign. When schizophrenia first develops, the already sensitive introvert goes through a phase of heightened sensitivity.

CRITERIA FOR EVALUATING THE ADMINISTRATION OF A PUBLIC HEALTH NURSING SERVICE—published by the National League for Nursing. This pamphlet lists 16 criteria for evaluating basic elements in the administration of public health nursing services. The criteria were formulated by a special committee from the 400 public health nursing services that are member agencies of the NLN's Department of Public Health Nursing. Available from National League for Nursing, 10 Columbus Circle, New York 19, N. Y. Single copies, 25¢.

PLANNING OF FACILITIES FOR MENTAL HEALTH SERVICES—Public Health Service Publication No. 808 by the Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities. The committee presents its findings on treatment trends and current problems in providing mental health facilities. Principles of planning statewide plans for the provision of adequate facilities are discussed, as well as factors impeding the effective implementation of such plans. Available: Superintendent of Documents, Government Printing Office, Washington 25, D. C. 40¢.

MEDICAL AND DENTAL X-RAYS—published in *Consumer Reports,* September 1961. Professor Hanson Blatz, director of New York City's Office of Radiation Control, says that if medical and dental X-ray exposure could be cut by even a few per cent, the effect would be "more than equivalent to eliminating all other sources of man-made radiation exposure." Consumers Union, publisher of *Consumer Reports,* offers suggestions for less hazardous use of X-rays, including advice to patients and recommendations for legal approval, registration, and inspection of X-ray equipment.

Reviews & Commentary



FILM REVIEWS

EXTERNAL CARDIAC MASSAGE (color 22 minutes). Produced by Smith Kline & French Laboratories. Available from SK&F Medical Film Center (Philadelphia 1, Pa.) or from SK&F representatives for showing to professional audiences. .

Although cardiac arrest occurs rarely in electroshock therapy, it happens frequently enough to warrant instruction in necessary first-aid measures. For this reason, mental hospital staffs will be interested in this dramatic presentation of a resuscitative technique which does not require the opening of the chest. This method, recently developed at the Johns Hopkins Hospital, is demonstrated by James R. Jude, M.D.; W. B. Kouwenhoven, Dr. Ing.; and G. Guy Knickerbocker, M. S. E. Working on several kinds of patients, they show the steps required to reverse cardiac standstill in time to prevent damage to the brain and other organs. To be successful, the manual technique (combined with assisted ventilation) must be applied within four minutes after the heart stops beating.

Animated sequences show how manual depression of the lower sternum compresses the heart, forcing blood into the pulmonary and systemic vessels. Release of pressure allows the chest to expand and the heart to fill again. In the live action sequences, showing actual procedures with living models and equipment, the three demonstrators handle their chores with precision. Dr. Jude's accompanying commentary, although quite technical, is a model of clarity. Another interesting feature of the film is an interview with a successfully revived patient whose heart had gone into ventricular fibrillation one year earlier.

As a medical teaching film, "External Cardiac Massage" has few equals from the standpoint of using the film medium effectively. Intended for professional audiences only, it will be helpful to all mental hospital personnel who administer electroshock therapy. Students of medicine and nursing also will find it fascinating. An excellent illustrated handbook on external cardiac massage has been prepared by the producers as a refresher for the points made in the film.

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THE OPEN HOSPITAL (black and white, 29 minutes) Produced by the National Educational Television Film Service. Available for sale or rental from NET Film Service, Indiana University, Bloomington, Indiana.

In this kinescope of an educational TV program, moderator Steven Palmer interviews Dr. Herman Snow, superintendent of the St. Lawrence State Hospital, New York. As Dr. Snow describes the philosophy behind the "open door" concept, we are shown the various changes that have taken place in this hospital as a result of this innovation. Both Dr. Snow and the film eloquently make the point that the open hospital helps to restore dignity and pride to the mental patient and is an effective adjunct to therapy.

Even the statistics are interesting: the hospital's total census has dropped noticeably in spite of an increase in voluntary admissions from 26 per cent to 60 per cent; fewer tranquilizing drugs and restraint measures are needed for disturbed patients. Although readers of Dr. Snow's excellent articles on the open hospital will find nothing new in the film, audiences cannot fail to be moved by the sequences showing the patients' responses to the opening of the doors.

This is a fine film to show to the general public—to take them inside a well-run, progressive state hospital, to counteract fears about mental patients, and to explain therapy. It will also interest mental hospitals' staffs and volunteers—whether or not their hospitals are completely open—and will enlighten students of medicine, nursing, social work, public health psychology and theology. "The Open Hospital" is one of a series of 11 films, called "Escape from the Cage," made by National Educational Television. Reviews of other films from this series will appear in future issues of *Mental Hospitals.*

NOTE: Although neither of the films reviewed above is at present in the APA Mental Hospital Service Film Library, an impressive collection of titles is now available to

No Excuse for Health Hazards in Kitchen or food-serving areas!

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JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

THE COUCH AND THE CIRCLE—by Hyman Spotnitz, M.D., New York, Alfred A. Knopf, Inc., 1961, 276 pages, $4.50.

The author, a psychiatrist with a psychoanalytic orientation who is experienced in individual and group therapy, describes and illustrates the two methods and the indications for their use. He uses succinct case-histories, including the techniques, the difficulties, and the results. The book gains added depth through the author's frank discussion of his own training and development, his reactions, and his ways of thinking and dealing with situations as they arise.

In his preface, Dr. Spotnitz states that he wishes "to share his enthusiasm with the general public," and also that "he subordinates technique and theory to impressions of human beings." As in many such books, however, the author's enthusiasm may cause the lay reader to misunderstand the techniques. A careful reader with professional training, however, will gain considerable information about technique. The clarity with which the book is written will make it helpful also to the nonpsychiatric physician confused by the various techniques of psychotherapy and the different types of group therapy. It will also be useful for the trainee beginning to study psychotherapy and group therapy.

The book includes a brief history of group therapy and a discussion of the various types, apparently recorded by their respective practitioners. The author includes discussions on the meaning of recovery and on confidentiality, two subjects which have long needed elucidation; these chapters could serve as the basis for further discussion.

The usefulness of the book would be increased by a bibliography and an index.

FLORENCE POWDERMAKER, M.D.
Ridgefield, Conn.

GROWING OLD, Problems of Old Age in the Australian Community— edited by Dr. Alan Stoller, Melbourne, Australia, F. W. Cheshire, 1960, 205 pages.

This book is an account of a conference on the problems of the aging citizen, written in an interesting and concise style. Like the U.S.,

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References (1) Moss, N. H.; Morrow, B. A.; Long, R. C., and Ravdin, I. S.: J.A.M.A. 140:1336, 1949. (2) Niemiro, B. J.: Journal-Lancet 71:364, 1951. (3) Combes, F. C.; Zuckerman, R., and Kern, A. B.: New York J. Med. 52:1025, 1952. (4) Lowry, K. F.: Postgrad. Med. 11:523, 1952. (5) Diamond, O. K.: New York J. Med. 59:1792, 1959.

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Australia puts great emphasis on opportunities for young people, while its over-65 group is expanding rapidly. Experts in psychiatry, geriatrics, general medicine, psychology, economics, nursing, religion, and education were involved in this major conference.

Although few American gerontologists are mentioned, and the book lacks references, it will be of interest over here as the description of another country's attempts to cope with the geriatric problem.

KURT WOLFF, M.D.
Coatesville, Pa.

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling.

SOME PROBLEMS IN MENTAL HOSPITAL DESIGN
The Salt Lake VA Hospital, Utah, was the first of a series of post-World War II VA hospitals designed according to the patient-care philosophy of Dr. P. Haun. The author describes the hospital and discusses some of the problems and benefits resulting from its design. In addition to this study, the author has conducted research on patients' opinions and attitudes about several aspects of the hospital's design. Both papers are available from Gary A. Davis, Department of Psychology, University of Utah, Salt Lake City 12.

EXPLORING SOCIAL SERVICE DISCHARGE PLANS FOR MENTAL PATIENTS. PART I: WORK RESOCIALIZATION PROGRAM
A two-stage experiment on resocialization, supported by an NIMH grant to The Menninger Foundation, is being conducted at Osawatomie State Hospital, Kans. Resocialization is conceived as both educational and therapeutic, achieved through social interaction in a structured environment. Available from Medical Library, Osawatomie State Hospital, Box 500, Osawatomie, Kans. (*Handling charge, $2*)

REMUNERATION AND INCENTIVE PILOT STUDY FOR INDUSTRIAL PATIENTS
This is the report of a project to provide remuneration for working patients, remotivate them toward greater participation in the hospital community, establish a balanced work-play environment, and provide an incentive for other patients to accept industrial therapy assignments. Available from Mr. Jerry J. Beauchamp, Chief, Industrial Therapy Department, San Antonio State Hospital, P. O. Box 1840, San Antonio, Texas.

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1. Fincle, L. P., and Reyna, L. J.: J. Clin. & Exper. Psychopath. 19:7 (Mar.) 1958.

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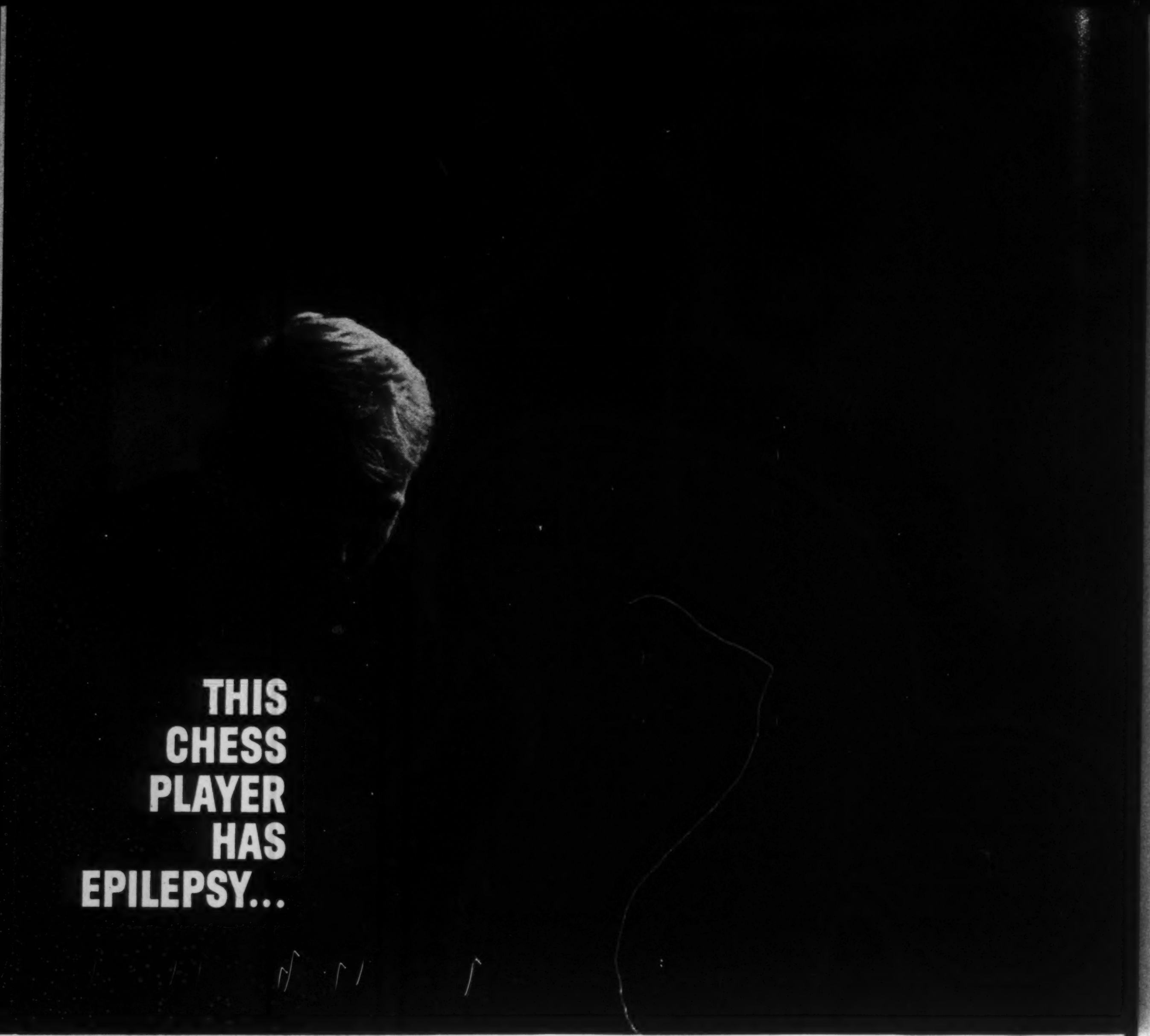

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News and Notes

Optimistic Comments on ECFMG

Of 182 foreign-trained medical graduates who took the April 1961 examination of the Educational Council for Foreign Medical Graduates, roughly 58 per cent (105) passed, 7 per cent (13) passed conditionally, and 35 per cent (64) failed. These figures are based on the reports of eleven states which had been having particular problems because so many of their psychiatric staff members were foreign-trained.

Commissioners in these states expressed some optimism that in the long run the ECFMG program will be of help in upgrading the level of treatment in mental hospitals, although some immediate problems are still pressing. Apparently a fair number of foreign graduates, highly valued in their hospital, have either failed to pass the examination or have not taken it. Their administrators are pleading for enough time to allow these physicians to pass the examination.

Minnesota Appoints Lay Administrator

The Commissioner of Public Welfare, authorized by a special rider to the 1959 and 1961 Welfare Appropriations Act, has appointed Dr. Vera Behrendt, formerly superintendent, as medical director of Willmar State Hospital, and Mr. Lester Johnson, formerly assistant superintendent, as hospital administrator. The medical director will be in charge of treatment, research, and rehabilitation programs in the hospital. Both Dr. Behrendt and Mr. Johnson will report to Dr. David J. Vail, Director of Medical Services Division of the Department of Public Welfare. The appointments, authorized in June by the Medical Policy Directional Committee on Mental Health, became effective on September 6th.

The legislation provided for the appointment of a licensed physician as chief of the medical staff and of a professionally trained hospital administrator as chief executive officer. Since the June meeting, the hospital and the department have been working to establish lines of authority and command.

Proponents of the plan, which is bitterly opposed by some psychiatrists, hope that it will clarify areas of responsibility and competence for medical care and for hospital administration, leading to improvement of both services.

PEOPLE and PLACES

WISCONSIN: The Division of Mental Hygiene of the State Department of Public Welfare has recently moved its office from 1552 University Ave., Madison 5 to 1 West Wilson St., Room 344, Madison 2.

Kenneth H. Rusch, M.D., recently in private practice in Hawaii, has been named director of community clinic service, Division of Mental Hygiene, State Department of Public Welfare.

INDEX TO ADVERTISING **OCTOBER 1961**

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